Welcome to Dr. Sherick's Office

Thank you for completing this form and for providing this important information.
Print clearly and complete both sides. A signature is required.

Patient's Name: ______________________ Nickname: __________ ☐ Female ☐ Male
Date of Birth: ____/____/____ Age: ________ Patient interests:______________________
Home address:____
How long at this address? ____________
Previous address (if less than three years): ______________________________
Home phone :(___)____________ Work phone:(____)____________ Cell phone:(____)____________
When is the best time to reach you?______________________________
Primary Family Email Address:______________________________

By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology.

Whom may we thank for referring you?______________________________
Other family members seen by us: ______________________________
Marital Status: Single Married Divorced Widowed Separated Partnered

Employer:____________________ Occupation:______________ Years of Employment:________
Employer Address:____
Social Security Number:____________________Driver's License Number:____________________

Spousal Information
His/Her Name:______________________________Date of Birth: ____/____/____
Employer:____________________ Occupation:______________ Years of Employment:________
Work Phone: (________)____________ Cell Phone :(______)____________

Person(s) Financially Responsible for the Account:
Name(s):______________________________ Relation:____________________
Billing Address:____
Previous Address:____
Employer:____________________ Occupation:______________ Years of Employment:________
Home Phone: (______)____________ Work Phone: (______)____________ Cell Phone :(______)________
Social Security Number:____________________Driver's License Number: ____________________

EMERGENCY CONTACT-Person not residing with you
Name:______________________________ Relation:____________________
Home Phone: (______)____________ Work Phone: (______)____________ Cell Phone :(______)________

Primary Dental Insurance (not Health Insurance)
Orthodontic Coverage/Benefit: Yes/No
Insurance Company Name and Address:____
____
Insurance Company Phone Number: (______)______________ Employer:____________________
Policy Holder/Subscriber Name:____________________________ Date of Birth: ____/____/____
Relation to Patient:______________ Subscriber ID/SSN: ____________________ Group #:__________
Insurance card available: Yes/No

Secondary Dental Insurance (not Health Insurance)
Orthodontic Coverage/Benefit: Yes/No
Insurance Company Name and Address:____
____
Insurance Company Phone Number: (______)______________ Employer:____________________
Policy Holder/Subscriber Name:____________________________ Date of Birth: ____/____/____
Relation to Patient:______________ Subscriber ID/SSN: ____________________ Group #:__________
Insurance card available: Yes/No

MEDICAL HISTORY

Name of Physician:___________________________Current Medical Problems:______________________

Have you ever been diagnosed with any of the following diseases or medical conditions?

Condition			Condition			Condition		
Abnormal or Excessive Bleeding	Y	N	Delayed development	Y	N	Nervous disorder	Y	N
ADD/ADHD	Y	N	Diabetes	Y	N	Pacemaker	Y	N
Allergies to Drugs	Y	N	Endocrine problems	Y	N	Pregnancy	Y	N
Allergies to Latex or metals	Y	N	Emotional problems	Y	N	Currently Pregnant	Y	N
Allergies to Plastics	Y	N	Fainting or dizziness	Y	N	Psychiatric treatment	Y	N
Any hospital stays	Y	N	Glaucoma	Y	N	Rheumatic/Scarlet fever	Y	N
Any surgeries	Y	N	Handicaps or disabilities	Y	N	Sinus trouble	Y	N
Artificial bones, joints, valves	Y	N	Headaches (recurrent)	Y	N	Stomach ulcers	Y	N
Asthma	Y	N	Hearing impairment	Y	N	Stroke	Y	N
Bone disorders	Y	N	Heart disease	Y	N	Tonsillitis (recurrent)	Y	N
Cancer or malignancies	Y	N	Heart murmur	Y	N	Tuberculosis	Y	N
Congenital heart defect	Y	N	Hepatitis (A/B/C) (please circle one)	Y	N	Other_______________		
Convulsions, epilepsy or seizures	Y	N	High blood pressure	Y	N			
			HIV/AIDS	Y	N			
			Kidney/liver problems	Y	N			

Please provide additional information if you answered yes to any of the above:______________________________

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Please describe your current physical health: Good Fair Poor

List any medication you are currently taking:____

List all drug allergies or sensitivities (not previously mentioned):__________________________

Have you ever taken any of the following? Fen-Phen Redux Pondimin Zometa Aredia Boniva Actonel Fosamax

If so, when?_____________________________________ Dosage:_______________________

DENTAL HISTORY

Name of Dentist:______________________ Office phone:____________Date of last check-up:________

What are your main concerns that you would like orthodontics to address?__________________________

Have you consulted another orthodontist? Yes/No When? ______________________________

Do you brush your teeth daily? Yes/No Do you floss daily? Yes/No

Have you ever exhibited or been treated for any of the following?

Y	N	Injury to the face, mouth or jaws	Y	N	Tongue thrusting
Y	N	Removal of adenoids or tonsils	Y	N	Teeth grinding/clenching
Y	N	Extraction of teeth	Y	N	Speech therapy
Y	N	Mouth breathing/snoring	Y	N	Thumb/finger sucking
Y	N	Pain or clicking in jaw joints	Y	N	Lip biting
Y	N	Missing or extra permanent teeth	Y	N	Nail biting
Y	N	Previous orthodontic treatment			

Please provide additional information if you answered yes to any of the above:______________________________

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I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

____

Signature Date

*This office will not be held responsible for any problems arising from information not disclosed.

I have authorized the Orthodontist to share my treatment information with collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit pertinent information to the insurance company for billing purposes only.

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Signature Date