

Dr. Scott B. Edmonds | 2949 SW Wanamaker Dr. | Kansas 66614
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WELCOME to our office! Please help us serve your needs by completing this information sheet.

Today's Date: _____

Name: _____ Preferred First Name: _____

Date of Birth: _____ Age in years: _____ Male / Female Home Phone: _____

Home Address: _____ City, State, Zip: _____

Billing Address: _____ City, State, Zip: _____

Employer: _____ Work Phone: _____

Business Address: _____ SSN: _____

Spouse's Name: _____

Employer: _____ Work Phone: _____

Business Address: _____ SSN: _____

Person(s) (other than you or your spouse) responsible for account:

This person's SSN: _____

Address: _____ City, State, Zip: _____

Employer: _____ Work Phone: _____ Home Phone: _____

Business Address: _____ City, State, Zip: _____

Are you covered by orthodontic insurance? _____ If yes, please provide an insurance card (if available).

Insured's Name: _____ Insurance Company: _____

Insured's Date of Birth: _____ SSN: _____ Group #: _____

Insurance Co's Address: _____ Insurance Co's Phone: _____

Whom may we thank for referring you to our office?

Has your family dentist expressed specific orthodontic concerns?

What is your primary reason for seeing the orthodontist?

Do you have any specific concerns regarding orthodontic treatment?

Is there anything about the appearance of your teeth or facial profile that you would like to see changed?

Have you or any other family members been treated by our office? _____ Names: _____

Have you ever been seen or treated by another orthodontist? _____ Orthodontist's Name: _____

City: _____ How long did treatment last? _____

What did the treatment involve? _____

Do you anticipate a move or transfer in the near future?

Medical Information

Physician: _____ City: _____

Date of last physical exam: _____ Height: _____ Weight: _____

Are you in good health? Yes / No If "No" please explain: _____

Do you have a history of any major illness?

Are you currently under a physician's care for illness?

Have you had any major operations?

Have you had general/local anesthesia complications?

Have you been hospitalized in the last five years?

Do you have any prosthetic joints/implants?

Do you require antibiotic pre-medication for dental procedures?

Do you know or suspect that you are pregnant? _____ Week #: _____

Do you smoke or chew tobacco? _____ If so, how long?

Circle any of the following conditions which are applicable to you:
Anemia/Radiation Treatment Epilepsy/Seizures/Fainting Spells Immunity Disorders
Asthma/Allergies/Arthritis Fever Blisters/Herpes Kidney Problems
Blood Transfusion Heart Attack/Stroke Mitral Valve Prolapse
Brain Disorder Heart Murmur Psychiatric Problems
Cancer/Chemotherapy Ulcers/Colitis/Stomach Problems Rheumatic/Scarlet Fever
Congenital Heart Disease Heart Surgery/Pacemaker Recent Cold or Flu
Diabetes/Tuberculosis (TB) Hemophilis/Abnormal Bleeding Severe/Frequent Headaches
Difficulty Breathing Hepatitis/Liver Disorder Shingles
Drug/Alcohol Abuse High/Low Blood Pressure Sinus Problems
Emphysema/Glaucoma HIV+/AIDS Venereal Disease
Are there any conditions an orthodontist or oral surgeon should be aware of?

Are you allergic to any of the following? Dental Anesthesia Aspirin Latex
Penicillin Codeine Tetracycline Any Metal/Plastic Erythromycin
Other: _____

List medications you are currently taking. Give reasons:

Are you taking or have you ever taken a bisphosphonates type medication (examples: Fosamax, Didronel, Boniva, Actonel, Zometa) _____

Please use this space for additional comments:
Dental Information

Family Dentist: _____
Date of last check-up: _____ Date of last cleaning: _____ Date of last dental x-rays: _____

Have any permanent teeth been removed by the dentist?

Were there any complications with tooth extractions?

Have you ever had any injuries to the face, mouth, teeth, or chin?

Have you ever lost any teeth due to trauma?

Have you had any periodontal (gum) problems?

Have you had trouble with bleeding gums?

Do you clench or grind your teeth?

Do you have clicking or pain near the ears?

Do you have chronic headaches or facial pain?

Is breathing through your nose difficult?

Have you had your tonsils or adenoids removed? Yes/ No

Do you have any speech problems?

Have you ever been treated by a speech pathologist?

Has anyone in the family had jaw surgery to correct a strong or weak chin?

I certify that the above information is correct to the best of my knowledge. I will notify Dr. Edmonds of any changes in my medical status.

I authorize Dr. Edmonds office to release pertinent information to my insurance company. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____