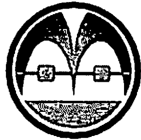

VANCE MISURACA ORTHODONTICS

Specializing in Braces & Invisalign for Children & Adults

Baton Rouge
10720 N. Oak Hills Pkwy.
Baton Rouge, LA 70810

Prairieville
16206 Airline Hwy.
Prairieville, LA 70769

Denham Springs
238 Veterans Blvd.
Denham Springs, LA 70726

Central
15299 Wax Rd.
Central, LA 70818

(225) 766-3300 • Fax: (225) 677-9483 • MisuracaOrthodontics.com

Confidential Patient Information

Name: ______________________ (Last / First / Middle) Email: ____________

Address: ______________________ (Street / City / State / Zip) Cell: ____________

Home Phone: ____________ Birthdate: ____________ Social Security #: ____________

If patient is a minor, give parent's or guardian's name: ____________ School: ____________

Whom may we thank for referring you to our office? ____________

Confidential Responsible Party Information

Marital status: ____________

Name: ______________________ (Last / First / Middle)

Email: ____________

Residence: ______________________ (Street / City / State / Zip)

Cell: ____________

Mailing Address: ______________________ (Street / City / State / Zip)

Work phone: ____________

How long at this address: ____________ Home phone: ____________

How long at this address: ____________

Do you rent or own? ○ Rent ○ Own

Previous address (if less than 3 yrs): ______________________ (Street / City / State / Zip)

Social Security #: ____________ Birthdate: ____________ Relationship to patient: ____________

Employer: ____________ Occupation: ____________ No. of years employed: ____________

Spouse's name: ______________________ (Last / First / Middle) Relationship to patient: ____________

Social Security #: ____________ Birthdate: ____________ Work phone: ____________

Employer: ____________ Occupation: ____________ No. of years employed: ____________

Will you be paying as part of a trade group? ○ Yes ○ No If yes, which group? ____________

Dental/Orthodontic Insurance Information

Policy holder's name: ____________ DOB: ____________ Social Security #: ____________

Insurance company: ____________ Group #: ____________ Member ID: ____________

Insc. Co. address: ____________ Insc. Co. Phone: ____________

Policy holder's employer: ____________

Do you have dual coverage? ○ Yes ○ No If yes, then please fill out the information below:

Policy holder's name: ____________ DOB: ____________ Social Security #: ____________

Insurance company: ____________ Group #: ____________ Member ID: ____________

Insc. Co. address: ____________ Insc. Co. Phone: ____________

Policy holder's employer: ____________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor): ____________

Updates (date & initial): ____________

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Dental History

Are you or is your child currently in pain today? ○ Yes ○ No Primary reason for today's visit: ____________________

Have you or your child experienced any problems with past dental work? ○ Yes ○ No

Do you or does your child brush daily? ____________________ Floss daily? ____________________

Previous / Present dentist: ____________________ Date of last visit: ____________________

Why did you leave your previous dentist? ____________________

What did you like most about any dentist you've seen? ____________________ Least? ____________________

Do you or does your child have/had any of the following habits?

- ○ Lip sucking/biting
- ○ Nail biting
- ○ Chewing on objects
- ○ Clenching/Grinding teeth
- ○ Thumb/Fingers sucking
- ○ Nursing bottle habits
- ○ Tongue/Cheek biter
- ○ Used pacifier
- ○ Tongue thrust
- ○ Mouth breather
- ○ Speech problems
- ○ Breast feeding

Medical History

You or your child's physician: ____________________ Phone #: ____________________ Date of last visit: ____________________

Physician's address: ____________________
Street City State Zip

Are you or is your child currently under the care of a physician? ○ Yes ○ No Please explain: ____________________

Describe the patient's current physical health: ○ Good ○ Fair ○ Poor Are immunizations current? ○ Yes ○ No

Please list all drugs/medications patient is currently taking: ____________________

____

Please list any drugs/medications or other things that cause allergic reactions: ____________________

____

Has the patient had/experienced any of the following?

- ○ Abnormal bleeding
- ○ AIDS/HIV+
- ○ Allergies
- ○ Anemia
- ○ Asthma
- ○ Blood transfusion
- ○ Cancer
- ○ Chicken pox
- ○ Congenital heart defect
- ○ Convulsions
- ○ Diabetes
- ○ Epilepsy
- ○ Handicaps/Disabilities
- ○ Hearing impairment
- ○ Heart murmur
- ○ Hemophilia
- ○ Hepatitis
- ○ High blood pressure
- ○ Hives
- ○ Hospital stay/Operations
- ○ Kidney problems
- ○ Liver problems
- ○ Low blood pressure
- ○ Lupus
- ○ Measles
- ○ Mitral valve prolapse
- ○ Mononucleosis
- ○ Rheumatic fever
- ○ Scarlet fever
- ○ Sickle cell anemia
- ○ Skin rash
- ○ Tonsillitis
- ○ Tuberculosis

Please discuss any serious medical problems the patient has/had experienced: ____________________

____

Emergency Information

Name of nearest relative not living with you: ____________________

Complete address: ____________________

Phone: ____________________ Relationship: ____________________