(913)-782-7223
(913)-780-1886
smile@moonortho.com
www.moonortho.com
601 N. Mur-Len, Suite 3, Olathe, KS 66062 / 14247 Metcalf Ave, Overland Park, KS 66223

ABOUT YOU

FIRST NAME:	MIDDLE NAME:	LAST NAME:	
PREFERRED NAME/NICKNAME:	AGE:	DATE OF BIRTH:	GENDER: ◯ M ◯ F
DAYTIME PHONE #:	CELL #:	EMAIL:	
ADDRESS:	CITY:	STATE:	ZIP:
EMPLOYER:	OCCUPATION:	HOW LONG?	

HOW DID YOU HEAR OF MOON ORTHODONTICS?

WHAT IS THE REASON YOU ARE SEEKING AN ORTHODONTIC EVALUATION?

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ◯ YES ◯ NO REASON:

WHERE?	WHEN?

PLEASE LIST OTHER FAMILY MEMBERS SEEN IN OUR OFFICE AND THEIR RELATION TO YOU:

SPOUSE'S NAME?	PLEASE LIST ANY CHILDREN(AGE):

DENTAL INSURANCE INFORMATION

MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ PARTNERED ◯ WIDOWED ◯ DIVORCED ◯ SEPARATED

PRIMARY INSURANCE COMPANY NAME:		SECONDARY POLICY HOLDER NAME:	
ADDRESS:		ADDRESS:	
GROUP ID:	MEMBER ID:	GROUP ID:	MEMBER ID:
PRIMARY POLICY HOLDER NAME:		SECONDARY POLICY HOLDER NAME:	
SSN: ____/____/____	DATE OF BIRTH: ___/___/___	SSN: ____/____/____	DATE OF BIRTH: ___/___/___
RELATIONSHIP TO PATIENT:		RELATIONSHIP TO PATIENT:	
DO YOU PARTICIPATE IN A FLEX PLAN? ◯ YES ◯ NO		DO YOU PARTICIPATE IN A FLEX PLAN? ◯ YES ◯ NO	

MEDICAL HEALTH INFORMATION

HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL PROCEDURE OR SERIOUS ILLNESS? ◯ YES ◯ NO

NAME OF YOUR PHYSICIAN:	PHONE:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

ADD/ADHD ◯ YES ◯ NO	Fainting Spells, Seizures ◯ YES ◯ NO	Joint Replacement or Implant ◯ YES ◯ NO
AIDS, HIV POSITIVE ◯ YES ◯ NO	Heart Defect, Heart Murmur, Heart Disease ◯ YES ◯ NO	Scarlet Fever, Rheumatic Heart Disease ◯ YES ◯ NO
Asthma ◯ YES ◯ NO	Hepatitis ◯ YES ◯ NO	Tonsillitis ◯ YES ◯ NO
Excessive Bleeding / Bruising ◯ YES ◯ NO	Herpes/Fever Blisters ◯ YES ◯ NO	Tonsils or Adenoids Removed ◯ YES ◯ NO
Cancer ◯ YES ◯ NO	High or Low Blood Pressure ◯ YES ◯ NO	Tuberculosis ◯ YES ◯ NO
Diabetes ◯ YES ◯ NO		

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DO YOU NOW OR HAVE YOU EVER TAKEN BISPHOSPHONATES, INCLUDING FOSAMAX, DIDRONEL, BONIVA, AREIDA, ACONTEL, SKELID, OR ZOMETA? IF SO, WHICH DRUG?

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED THAT YOU THINK WE SHOULD KNOW ABOUT? PLEASE EXPLAIN:

ARE YOU ALLERGIC TO LATEX, NICKEL, OR METALS?

OTHER SENSITIVITIES/ALLERGIES:

ARE YOU TAKING ANY MEDICATION AT THIS TIME? ◯ YES ◯ NO If yes, please list:

DENTAL HEALTH INFORMATION

ARE YOU EXPERIENCING ANY DENTAL PROBLEMS? ◯ YES ◯ NO

DATE OF LAST DENTAL VISIT: ______ / ______ / ______

HOW OFTEN DO YOU BRUSH AND FLOSS EACH DAY? Brush ______ times per day. Floss ______ times per day

DENTIST:

ADDRESS:

PHONE:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Difficulty Chewing	◯ YES ◯ NO	Jaw Pain (Joint, Ear, Side Of Face)	◯ YES ◯ NO	Permanent Tooth Extraction	◯ YES ◯ NO
Clenching or Grinding	◯ YES ◯ NO	Tongue Thrust	◯ YES ◯ NO	Tooth Sensitivity To Heat, Cold, Or Sweets	◯ YES ◯ NO
Finger or Lip Sucking Habit	◯ YES ◯ NO	Head/neck, Jaw Or Tooth Injury	◯ YES ◯ NO	Previous Orthodontic Treatment	◯ YES ◯ NO
Chronic Mouth Breather	◯ YES ◯ NO	Missing Or Extra Permanent Teeth	◯ YES ◯ NO	Clicking Or Popping Of The Jaw Joints	◯ YES ◯ NO
Soda/Juice Over Consumption	◯ YES ◯ NO	Sore Or Bleeding Gums	◯ YES ◯ NO	Fear Of Dental Work	◯ YES ◯ NO

I have read and understand the above questions. I will not hold Dr. Moon or and member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

SIGNATURE OF PATIENT

DATE