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

Name: _____ (Last / First / Middle) Marital status: _____

Residence: _____ (Street / City / State / Zip) Email: _____

Mailing Address: _____ (Street / City / State / Zip) Cell: _____

How long at this address: _____ Home phone: _____ Work phone: _____

Previous address (if less than 3 yrs): _____ (Street / City / State / Zip) How long at this address: _____

Do you rent or own? ◯ Rent ◯ Own

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 (VERY IMPORTANT)

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: _____