Robert S. Muirhead, DDS,MS

Specializing in Orthodontics for Children & Adults

16116 Stuebner Airline Rd/Spring TX 77379/281-376-5858

Patient Name______________________________Male___ Female___

Social Security #______________________________Birth Date__________________

Home Address____

City__________________________State__________Zip__________________

Primary Phone#______________________Home____ Cell____ ok to leave message Y___ N___

Secondary Phone # ____________________Home____Cell____ Other___ ok to leave message Y___ N___

Email Address____

Employer's Name______________________________________

Marital Status Single___ Married___ Divorced___ Widowed ___ Significant Other___

Spouse/Partner's Name____

Address if different______________________________City__________State______Zip__________

Phone#________________________________Relation ____________________________

Person(s) OK to release appointment/treatment/financial related information to concerning you.

______________________________________Relation______________________________

Primary Insurance
Company______________________________Phone#____________________________

Policy Holder's Name______________________Relation____________Birth Date______________

Social Security/ID#________________ Employer______________________Group#______________

Secondary Insurance Company____________________Phone #____________________________

Policy Holder's Name________________________Relation____________Birth Date____________

Social Security#/ID#______________________Employer____________________Group#__________

General Dentist______________________________Last Visit______________________________

How did you hear about our office?Ad___ Internet___ Family/Friend___ Physician___ Other___

Name of person referring you (if applicable)____

What are your main concerns you would like orthodontics to accomplish?

Have you visited an orthodontist before? Y___ N___

When?________________________________Reason____

Have your tonsils been removed?Y___ N___Have you ever had an injury to(select all that applies) Teeth___Mouth___Chin___

Have you ever experienced jaw joint pain/discomfort(TMJ/TMD) ? Y___ N__Do you have any missing/extra teeth? Y___N___

Do you have speech problems? Y___ N___ If so, explain____

Do your gums bleed? Y___ N___ Do you smoke? Y___ N___ Do you like your smile? Y___ N___

Do you currently or have you ever had any of the following habits(check all that apply) ?

Clenching/Grinding _____ Nail Biting_____ Lip Sucking/Biting _____
Thumb/Finger Sucking ____ Mouth Breathing ____ Chewing/Eating Problems ___

Are you currently being treated by a physician? Y___ N__ Physician_________________________Phone____________

Reason____

Do you have any allergies/sensitivities to medications or latex? Y___ N___ If yes, please list allergies__________________

Please list any prescriptions/medications you are taking at this time.____

Are you pregnant or nursing? Y___ N___

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

*I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

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

Patient Signature and/or Responsible Party(i.e. POA or Guarantor)____________________________________

Date________________________________