Welcome

STRICKLAND ORTHODONTICS
Improving Life One Smile at a Time
Fairhope | Spanish Fort | Bay Minette | Foley

H. L. Strickland Jr, DDS

Stephen Strickland, DMD, MS
Diplomate, American Board of Orthodontics

Welcome!

Thank you for selecting Strickland Orthodontics for your orthodontic treatment need! We are proud to welcome you and your family to our practice to provide you with outstanding personalized care in a friendly and caring environment! We will always strive to provide you with the absolute best in orthodontic care to ensure you have an experience that exceeds your expectations!

Your initial visit will include a comprehensive orthodontic examination where we will take orthodontic records which include photographs and X-rays. During our visit, you will have plenty of time to discuss your concerns with Dr. Strickland and, if treatment is recommended, we will be able to discuss a plan that will allow you to achieve *your* best smile! We will also be able to discuss the estimated treatment length and fees associated with your care.

Please find the included forms which provide us important information to allow us to provide the best care for you and your family. If able, please complete the forms ahead of time and bring them in with you at your next appointment. Or, if more convenient, these forms are also digitally fillable that can be filled out on your computer, saved and sent to **Smile@StricklandOrthodontics.com.**

Thank you for the opportunity to help provide you and your family with excellent care to achieve beautiful and healthy smile! Please call our office (251.928.9292 or 251.272.3232) or visit our website at www.StricklandOrthodontics.com for directions and more information about our practice. We look forward to welcoming you to the **Family of Strickland Smiles**!

Sincerely,

Dr. H. Len Strickland

Dr. Stephen Strickland

And the Strickland Orthodontics Team

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History

Date:_____

PLEASE PRINT IN INK

Or fill out online at:

StricklandOrthodontics.com

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PATIENT INFORMATION

First Name: _____ Last Name: _____ Preferred Name: _____ Gender: _____

Birthdate: _____ Age: _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) Spouse's Name: _____

Employer: _____ Occupation: _____ # of years at current employer: _____

Business Address: _____City: _____ State: _____ Zip: _____ Business Phone: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Cell Carrier: _____

Email: _____

What is the primary concern of your smile? _____

What was your deciding factor to give us a call?_____

How did you hear about our office? Please list all that apply:

☐ Dentist ☐ Patient / Friend ☐ Newsletter ☐ Google ☐ Internet Search ☐School / Community event ☐Other: _____

Name of personal referral. We would like to say THANK YOU!: _____

Relatives or friends that currently are, or have previously been, in our care: _____

My hobbies include: _____

My favorite Foods: _____Music: _____ Book: _____ Sports Team: _____

One of the proudest moments of my life was: _____

PARENT INFORMATION (if applicable)

Parent /Guardian Name: _____Home Phone: _____ Birthdate: _____

Cell Phone: _____ Cell Carrier: _____

Email: _____

Address (if different from patient's): _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Employer's Address: _____City: _____ State: _____ Zip: _____

ACCOUNT INFORMATION

How would you prefer to receive appointment reminders? ☐ Email ☐ Text ☐ Home Phone ☐ Cell Phone

What is the best day time number? ☐ Home Phone ☐ Cell Phone ☐ Other:_____

Person responsible for account: ☐ SELF _____ Relationship to Patient: _____

Birthdate: _____ Email Address: _____ SSN: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone + Ext:_____

Employer: _____ Occupation: _____ # of Years at Current Employer: _____

INSURANCE INFORMATION

Do you have orthodontic coverage? ☐Yes ☐No Name of Primary Insurance Company: _____

Phone Number: _____ Group Policy Number: _____ID Number: _____

Insured's Name: _____ Relationship to Patient: _____ Insured's Date of Birth: _____

Insured's SSN: _____Insured's Employer: _____

Lifetime Max (if known): _____

over →

SMILE QUESTIONNAIRE

Do you feel your teeth are too: ☐ Small/Short ☐ Big/Long ☐ Crooked/Crowded ☐ Misshapen/Uneven ☐ Other:_____

Do you feel your front teeth are too: ☐ Far Forward/ Proclined ☐ Far Back/Upright ☐ Other:_____

Have you had previous orthodontic treatment? ☐ Yes ☐ No If yes, when? _____

Are you interested in esthetic treatment options such as clear braces or aligners? ☐ Yes ☐ No

If treatment is recommended, how soon would you prefer to begin? _____

What is the most important factor for you in considering orthodontics? ☐ Speed of Treatment ☐ Aesthetics During Treatment ☐ Cost ☐ Comfort

Any other smile concerns you have or information you would like us to be aware of? _____

_____

PATIENT MEDICAL HISTORY (Please check all that apply)

Y	N		Y	N		Y	N		Do you have any allergies to the following?		
☐	☐	Heart Disease/Disorder	☐	☐	Immune System Problems	☐	☐	Earaches	Y	N	
☐	☐	Mitral Valve Prolapse	☐	☐	HIV / AIDS	☐	☐	Sinus Trouble	☐	☐	Local Anesthetics
☐	☐	High / Low Blood Pressure	☐	☐	Hepatitis or Liver Disease	☐	☐	Asthma / Hay Fever	☐	☐	Penicillin or other Antibiotics
☐	☐	Anemia / Blood Disorders	☐	☐	Kidney Disease	☐	☐	Respiratory Problems	☐	☐	Any Metals (e.g. nickel, mercury, etc.)
☐	☐	Bone Disorders	☐	☐	Endocrine Problems	☐	☐	Sleep Apnea	☐	☐	Latex Rubber
☐	☐	Osteoprosis	☐	☐	Tumors / Growths	☐	☐	Seizures	☐	☐	Other (please list below)
☐	☐	Joint Replacement / Implants	☐	☐	Cancer / Radiation Treatment	☐	☐	Fainting / Dizziness	List any other illnesses: _____		
☐	☐	Arthritis	☐	☐	Tonsils / Adenoids Removed	☐	☐	Emotional Concerns	_____		
☐	☐	Diabetes	☐	☐	Brain Injury / Seizures	☐	☐	Psychiatric Care	_____		

Please provide more information on items checked "Y" to allow us to provide you with the best care: _____

_____

List any medications you are currently taking: _____

_____Have you ever taken oral or IV bisphosphonates? ☐ Yes ☐ No When? _____

Name of Physician: _____ Date of Last Health Examination: _____ For what? _____

PATIENT DENTAL HISTORY

Y	N		Y	N	
☐	☐	Injuries to Face, Mouth or Teeth	☐	☐	Informed of Extra (Supernumerary) Teeth
☐	☐	Ever sucked a Thumb / Finger. Until what age?_____	☐	☐	Does the patient have any family member with similar Dental / Orthodontic Condition?
☐	☐	Joint Pain or TMD	☐	☐	*If yes*, did they have orthodontic treatment to correct the condition?
☐	☐	Grinding or Clenching Teeth	☐	☐	Has the patient previously consulted an orthodontist?
☐	☐	Informed of Missing Teeth	If yes, would you mind us asking whom?_____		
☐	☐	Any dental work that needs to be completed? (i.e. cavities)			

General Dentist: _____ Date of Last Cleaning: _____

AUTHORIZATION AND RELEASE

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical or insurance status. I hereby authorize the release of all medical records on the above named patient to the referring dentist, physician or other health care provider, as well as information and records necessary for processing insurance claims. I hereby authorize release of any information and payment of insurance benefits directly to Strickland Orthodontics, PLLC. I authorize the release of financial information for collection and records transfer purposes. I authorize the necessary diagnostic tests and any orthodontic treatment deemed necessary to be performed by or under the direction of Dr. Strickland and/or associates of Strickland Orthodontics, PLLC. I give my permission for any photographs, x-rays or study models to be updated during treatment and to be used for displays in our office, on our website, at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I hereby authorize the necessary credit information to be obtained Strickland Orthodontics, PLLC or other third party company for the purposes of consideration of payment options. We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic account. The parent accompanying the child shall be responsible for payment of the services and seek any reimbursement from the other parent. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Signature: _____ Relationship to Patient: _____Date:_____

☐ or check if filling form digitally without a digital signature. I have read and authorize the release above and I have completed the above form accuractly