Orthodontic Specialist for Children & Adults

Smiles with Style!

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

PATIENT INFORMATION

Date: ______________ 20 ______

Name: ____
First Name / Middle Name / Last Name

Sex ☐ M ☐ F Age ______ Birthdate ____________ Nickname ______________ Hobbies ______________

Home Address: ____
Street / City / Zip

Home Phone ( ) ______________ Email ______________

School ______________ Grade ______ Patient's Dentist ______________

Name and ages of other children in family ______________

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

Person to contact in case of emergency:

Name: ______________ Phone ( ) ______________ Relationship to patient: ______________

FINANCIAL INFORMATION

Father's/Guardian's Name ______________

Address (if different for patient's) ______________

Home Phone ( ) ______________

Work Phone ( ) ______________

Cell Phone ( ) ______________

Employer ______________

Occupation ______________ # years employed ______________

Soc. Sec. # ____ - ____ - ____ Birthdate ____ - ____ - ____

Do you have orthodontic insurance coverage for minor/child? ☐ Yes ☐ No

Insurance Company ______________

Phone No. ( ) ______________ Group # ______________

Subscriber #: ______________

Address ______________

Mother's/Guardian's Name ______________

Address (if different for patient's) ______________

Home Phone ( ) ______________

Work Phone ( ) ______________

Cell Phone ( ) ______________

Employer ______________

Occupation ______________ # years employed ______________

Soc. Sec. # ____ - ____ - ____ Birthdate ____ - ____ - ____

Do you have orthodontic insurance coverage for minor/child? ☐ Yes ☐ No

Insurance Company ______________

Phone No. ( ) ______________ Group # ______________

Subscriber #: ______________

Address ______________

Signature for release of benefits to doctor

INFORMED CONSENT FOR CREDIT CHECKS: This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more reporting services.
I hereby certify that I have read and agree to this disclosure and give my permission to authorize such a check.

Responsible party sign here: ______________________________ Date: ____/____/____

MEDICAL HISTORY

Is patient in good health? ______ ☐ Yes ☐ No Does patient have any history of major illness? ______ ☐ Yes ☐ No

Has the patient ever been under the care of a physician for illness? ☐ Yes ☐ No Please list: ______________

Circle any of the following for which the patient has been treated: Diabetes AIDS Bone Disorders Nervous Disorders Herpes Asthma Anemia Epilepsy Headaches Tuberculosis Liver Involvement Heart Trouble Prolonged Bleeding Autoimmune Disorder Tumors (Cancer) Earaches (Soreness, Ringing Around Ears) Rheumatic Fever Kidney Involvement Fainting or Dizziness Arthritis or Rheumatism Drug Addiction or Alcoholism High (or Low) Blood Pressure

Have tonsils and adenoids been removed? ☐ Yes ☐ No At what age? ______________

List any drugs or medication now being taken. Give reasons: ______________

List any allergies or drug/latex sensitivity: ______________

Has the patient reached puberty? GIRLS: Has she started menstruation? ______ ☐ Yes ☐ No BOYS: Has his voice changed? ______ ☐ Yes ☐ No

<u>PLEASE COMPLETE BOTH SIDES</u>