Patient No. _____

Int. App't Date _____

Patient Information

Patient's Name _____ Nickname _____ Sex _____

Birthdate _____ Age _____ E-mail Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred method of contact: ☐Phone ☐Email ☐Text Carrier/Service Provider for text _____

Home Address _____
(Street) (City/State) (Zip)

Employer _____ Occupation/School _____

Patient resides with _____

In the event of an emergency, whom should we contact other than responsible party?

His/Her Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Which office do you prefer? Circle One: Hollymead Downtown Spring Creek

Responsible for Account **(Clinical and financial information can be released to responsible parties only) Mother ☐ Y ☐ N Father ☐ Y ☐ N

Primary Responsible Party

Name _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Birthdate _____ E-mail Address _____ Relation to Patient _____

Home Address _____
(Street) (City/State) (Zip)

Billing Address _____
(Street) (City/State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Carrier/Service Provider for text _____

Employer _____ Occupation _____

Secondary Responsible Party** _____ Relation to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Carrier/Service Provider for text _____

Home Address _____
(Street) (City/State) (Zip)

Birthdate _____ E-mail Address _____

Employer _____ Occupation _____

Orthodontic Insurance Information ☐ YES ☐ NO

Insured Full Name _____ Birthdate _____ Relation to Patient _____

Insured Address _____
(Street) (City/State) (Zip)

Insurance Group Number _____ Insurance ID Number _____

Employer Name _____ Insurance Company Name _____

Insurance Address _____
(Street) (City/State) (Zip)

Is this claim the result of an accident? YES NO

Continue on back side

Dental & Medical History

Patient's Dentist _____ Last Visit _____

Did your dentist refer you? ☐ YES ☐ NO If no, how did you find out about us? _____

Is the patient under a physician's care? ☐ YES ☐ NO Physician's Name _____

If yes, for what reason? _____

Previous orthodontic consulted? ☐ YES ☐ NO If yes, when? _____

Other Family members treated in this office _____

What are the main concerns that you would like to address with orthodontics? _____

_____

Please check if the patient has any allergies to the following?

☐ Latex ☐ Nickel/Metals ☐ Plastic ☐ Nuts ☐ Other

Please list any other material or drug allergies _____

_____

Please check any of the following condition(s) that patient has had or currently has:

☐ Thumb/Finger Sucking
☐ Clinching/Grinding Teeth
☐ TMJ
☐ Nail Biting
☐ Mouth Breather
☐ Tonsils and/or Adenoids Removed
☐ Obstructive Sleep Apnea
☐ Canker/Cold Sores
☐ Dental/Tooth Injuries
☐ Facial/Jaw Injury
☐ Speech Problems
☐ Heart Condition/Murmur
*Pre-Med Required** ☐ Yes ☐ No
☐ Diabetes
☐ HIV/AIDS
☐ Frequent Headaches
☐ Asthma
☐ Abnormal Bleeding
☐ Emotional Disturbance
☐ ADD
☐ Mental Disorders
☐ Arthritis
☐ Hepatitis
☐ Epilepsy/Seizure Disorder
☐ Prolonged Bleeding
☐ Tumor or Cancer
☐ Persistent Cough
☐ Tuberculosis
☐ Fainting Spells
☐ Rheumatic Fever

Pre-Teen / Teen Females Only

To aid in assessing growth potential, has menstruation started?

☐ Yes _____ (Mo / Yr) ☐ No (never had yet)
☐ Not yet started but imminent within one year
☐ Not sure

Other _____

Please list any medications the patient is currently taking _____

_____

The information given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes.

I authorize release of any information relating to orthodontic insurance claims.

**As a service to our clients, we provide a courtesy appointment reminder call and/or text message, and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls or text messages at this number.

_____

Signature (required) Relationship to patient Date

Drs. Notes: