NEW PATIENT INFORMATION

Patient's name ____
Last First Middle

Residence ____
Street City Zip

Mailing Address ____
Street City Zip

Email Address ______________________________ Birth Date ______________

Cell phone____________________ Patient Social Security # ______________________

Marital Status: Single_____ Married_____ Widowed_____ Separated_____ Divorced______

Employer________________________ Occupation ________________________

Spouse's Name __________________________ Relationship to Patient ______________

Employer ________________________ Occupation ________________________

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

Family Dentist__________________________ Date of last visit ______________

INSURANCE AND FINANCIAL INFORMATION

Insured's Name ______________________ Insured's Social Security # ______________

Dental Insurance Company ____

Do you have dual coverage? Yes _____ No _____ If yes, please fill out the following:

Insured's Name ______________________ Insured's Social Security # ______________

Dental Insurance Company ____

Do you have Flex Spending or Health Savings funds available? Yes _____ Amount $__________ No ______

Will you be the primary person responsible for the account? Yes ______ No _______

If no, who will be: Name ____________________ Relationship to Patient ______________

Mailing Address ____
Street City Zip

Email Address______________________ Cell Phone ______________________

FINANCIAL INFORMATION FOR FAMILIES WITH JOINT CUSTODY ONLY

I understand that in instances of separation or divorce, only one parent will be primary account holder and will be responsible for all payments due to our office. In the event of legal divided or joint financial responsibility for the child, it is the responsibility of the parents to facilitate any financial arrangements and reimbursements between themselves. Our office is not responsible for non-payment of the other party, nor we will mediate any financial disputes between parents. I also understand that our office will only work with the person listed as the primary account holder on all financial matters.

Initial ________________________ Date ___________________

MEDICAL HISTORY

Physician ____ Date of Last Visit __________________________

Address ____ Phone _________________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____

Yes No Are you allergic to latex or any medication? ____

Yes No Do you have a history of a major illness? ____

Yes No Have you had any operations? ____

Yes No Have you ever been involved in a serious accident?____

Yes No Have you ever smoked or chewed tobacco?____

Yes No Have seen your physician in the last 12 months? ____

Female Patients only:

Yes No Are you pregnant? If yes, estimated due date: _____________

Yes No Has menstruation started?

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? __________________________

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EMERGENCY INFORMATION

Name of nearest relative not living with you____

Complete address ____

Street City Zip

Cell Phone ________________________________ Home Phone ___________________________________

CONSENT FOR SERVICES

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes.

Initial: __________ I have read and understand our Notification of Privacy Practices.

Initial: __________ I have read and understand our Email and Electronic Communication Notification.

Initial: __________ I have read and understand our Disclosure of Health Information

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature: ____ Date: ____________________

Doctor Signature: ____ Date: ____________________