O.A.__________ T.V.______________________ N.V.______________________________________

(Above section for office use only)

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## PATIENT INFORMATION

Date: _____________ Patient's Name: ______________________________________________

Last First MI

Nickname: _____________________ Birth date: _____________ Age: ______

Gender: M F Home Phone: ____________ Cell Phone: ____________ Other: ____________

Address: ___________________________________________________________________

Street City State Zip

Email: ______________________________________________________________________

Preferred choice for appointment confirmation: Home phone Cell phone Text Email

Please list any family members we have treated: ____________________________________________

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## RESPONSIBLE PARTY INFORMATION

Name of individual(s) financially responsible for account:

(1)____________________________________________ Relationship to patient___________

Billing Address: _______________________________________________________________

Street City State Zip

Employer: ___________________ Work number__________ Do you have dental insurance? Y N

Name of spouse_____________________ Relationship to patient_______________

Employer: ___________________ Work number__________ Do they have dental insurance? Y N

(2)__________________________________ Relationship to patient_____________

Billing Address: _______________________________________________________________

Street City State Zip

Employer: ____________________ Work number_________ Do they have dental insurance? Y N

Name of spouse_____________________ Relationship to patient_________________

Employer: _____________________ Work number_________ Do they have dental insurance? Y N

**Emergency Contact Information**

Name of closest relative not living with you_____________ Relationship to patient_____________

Address____________________________________ Home number________________

## DENTAL HISTORY

Who may we thank for referring you to our office? ___________________________

Name of your general dentist: ___________________________

Has the patient had previous orthodontic treatment? Y N

If yes___________________________ ___________________________

Name of Orthodontist City and State

What was the approximate date of previous orthodontic treatment? ___________________________

What is the main orthodontic concern? ___________________________

Has the patient ever had any of the following? Please circle all that apply:

Yes-Apprehensive about dental care
Yes-Discomfort from teeth
Yes-Teeth that are shifting
Yes-Frequent canker sores
Yes-Thumb/finger sucking as a child
Yes- Any injuries to face, mouth, teeth
Yes -Speech therapy
Yes -Injury to either jaw
Yes -Clenching or grinding of teeth
Yes -Jaw joint pain
Yes - Tonsils/Adenoids removed
Yes - Requires pre-medication for dental care

If yes, please explain___________________________

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## MEDICAL HISTORY

Patient's physician ___________________________

Is the patient currently taking any medications? Y N

If so, please list: ___________________________

Has the patient ever had any of the following? Please circle all that apply:

Yes-Allergy to latex
Yes-Allergy to metals
Yes-Allergy to medications
Yes-Anemia-radiation treatment
Yes-Arthritis
Yes-Asthma
Yes-Heart attack-stroke
Yes-Heart murmur
Yes-Diabetes
Yes-Hepatitis
Yes-HIV+AIDS
Yes-Hormone therapy
Yes-Prolonged bleeding
Yes-Seizures/Epilepsy
Yes-Tuberculosis
Yes-Drug allergies
Yes-Requires pre-medication

Other: If you checked yes to any of the above, please explain: ___________________________

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I understand that the information I have given above is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that I may need during my diagnosis and treatment with my informed consent.

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 these paragraphs.

SIGNATURE: ___________________________ DATE: ___________________________

ORTHODONTIC INSURANCE INFORMATION

**PRIMARY INSURANCE**

Name of Policy Holder: ____________________________________________

Relationship to Patient: Self Father Mother Spouse Stepparent Guardian

Social Security # (Insured) __________ - __________ - ____________

Date of Birth (Insured) ____________________________________________

Name of Employer ____________________________________________

Name and Address of Insurance Company:

____________________________________________

____________________________________________

____________________________________________

Policy Number ________________________________________

**SECONDARY INSURANCE:**

Name of Policy Holder: ____________________________________________

Relationship to Patient: Self Father Mother Spouse Stepparent Guardian

Social Security # (Insured) __________ - __________ - ____________

Date of Birth (Insured) ____________________________________________

Name of Employer ____________________________________________

Name and Address of Insurance Company:

____________________________________________

____________________________________________

____________________________________________

Policy Number ________________________________________

**I authorize my insurance company to pay to Wees & Low Orthodontics insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature for all insurance claims. I authorize Wees & Low Orthodontics to release all information necessary to secure payment of benefits and understand I am financially responsible regardless of any insurance benefits.**

**Signature** ____________________________________ **Date** __________________