We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to do our best to enable you to have a beautiful smile that lasts a lifetime.

Patient Information:

Your Name:____
Last First MI

Birth Date:______/______/______ Age:_____ Sex: • Male • Female Common Name:____________________

Address:____
City State Zip Code

Home Telephone #:___________________ Work Telephone #:_________________ext______ Cell Phone #:___________________

Employer & Address:____
City State Zip Code

Social Security #:____/____/______ E-mail Address to Receive Appointment Info & Updates:__________________________________

Emergency Contact? ____________________________________Relation:__________________ Cell Phone#:__________________
Last First

Dentist:_______________________ Office:_____________________________ Date of last check-up or cleaning:_______________

Family Members Currently In Our Practice:____

How Did You Hear About Us? • Website/Google • Family Member/Sibling • Friends/Co-Workers • Other______________

Chief Complaints or Concerns Today: ____

Responsible Party(s) "if different from above"

Primary
Name:____
Last First MI
Address:____

____
City State Zip Code
Home Telephone #:________________________________
Work Telephone #:________________________________
Cell Phone #:_____________________________________
Employer:____
Address:__________________________________

____
City State Zip Code

Social Security #:____/___/_____ Birth Date:____/___/____

Secondary
Name:____
Last First MI
Address:____

____
City State Zip Code
Home Telephone #:________________________________
Work Telephone #:________________________________
Cell Phone #:_____________________________________
Employer:____
Address:__________________________________

____
City State Zip Code

Social Security #:____/___/_____ Birth Date:____/___/_____

Insurance Information

Verification of your orthodontic benefits

Patient Name:____ Birth Date:____/____/_____
Last First MI

Insurance Holder:____ Policy Holder's Birth Date:____/____/_____
Last First MI

Relationship to Patient:___________________________ Policy Holder's Social Security #:________________________

Insurance Company:____ Phone Number: __________________

Claim's Address:____
City State Zip Code

ID #:_______________________________________ Group Policy #:____

Age limit:__________________ Preauthorization Required:_________________ Deductible:________________________

(LT) Coverage: $________________at____________%____Waiting Period:_____________Co-Pay:_________________

How Paid: Automatic from TX Plan or Bill - One Time / Monthly / Quarterly / Semi-Annual / Annual

Primary or Secondary Insured Coordination of Benefits: Yes / No / Standard

Disclaimer:

The information on this form serves only to document that we have verified that you currently have orthodontic benefits, by contacting your insurance company. It does not guarantee that your insurance company will actually pay the claim. Your insurance company will not officially process any claims until after treatment is initiated. As a courtesy to all of our patients, we provide the service of filling claims and accepting payments directly from insurance companies. This deferment of expenses is a courtesy and does not abdicate the patient of the responsibility for payment of the claim if the insurance carrier fails to pay. If payment from an insurance company is not received within 3 months following submission of the claim, then the account balance will be transferred to the patient account and it will become due immediately.

Signature: ____ Date:__________________________________

Medical History

Growth and Development		
Any learning, behavioral, excessive nervousness, or communication problems?	Yes	No
Psychological counseling in the past or being considered in the near future?	Yes	No
History of problems with physical growth?	Yes	No

Central nervous system		
History of Cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	Yes	No
Sensory disorders: hearing or vision problems?	Yes	No

Cardiovascular system		
History of congenital heart disease, stroke, heart murmur, or heart damage from rheumatic fever?	Yes	No
Has the patient been recommended or undergone any heart surgery?	Yes	No
Any history of chest pains or high blood pressure?	Yes	No

Hematopoietic and lymphatic system		
Ever received a blood transfusion or blood products transfusion?	Yes	No
Bruise easily, have frequent nose bleeds, or bleed excessively from small cuts	Yes	No
More susceptible to infections than normal?	Yes	No
History of tender or swollen lymph nodes or glands?	Yes	No

Respiratory system		
History of pneumonia, cystic fibrosis, asthma, sinus problems, shortness of breath, or difficulty breathing?	Yes	No

Gastrointestinal system		
History of stomach, intestinal or liver problems?	Yes	No
History of hepatitis or jaundice?	Yes	No
History of eating disorders such as anorexia nervosa or bulimia?	Yes	No
History of unintentional weight loss?	Yes	No

Genitourinary system		
History of urinary tract infections, bladder or kidney problems?	Yes	No
Is the patient pregnant or possibly pregnant?	Yes	No

Endocrine system		
History of diabetes?	Yes	No
History of thyroid disorders or other glandular disorders?	Yes	No

Skin		
History of skin problems, cold sores, or canker sores (apthae)?	Yes	No

Extremities		
Limitations of use of arms or legs?	Yes	No
History of arthritis, joint bleeding, joints replacements, or other joint problems?	Yes	No
History of problems with muscle weakness or muscular dystrophy?	Yes	No

Allergies		
History of allergic reactions to medications? (Please list names of medications)	Yes	No
History hay fever, hives, or skin rashes?	Yes	No
Is the patient known to be allergic to latex?	Yes	No

Other

Please circle Yes or No to indicate which of the following that the patient has now, has recently been exposed to, or has had in the past:

Substance abuse, alcoholism, drug addiction?	Yes	No
Tuberculosis?	Yes	No
Bone disorders?	Yes	No
Bruxing?	Yes	No
Epilepsy?	Yes	No
Osteoporosis?	Yes	No
Cancer treatment?	Yes	No
Endocrine problems	Yes	No
Adenoids / Tonsils removed?	Yes	No
TMJ / TMD?	Yes	No
Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, tonsillitis)	Yes	No
Sexually transmitted disease (HIV / AIDS, genital herpes, gonorrhea, syphilis or other)	Yes	No

Please list all medications which the patient is currently taking or any medications which the patient takes occasionally including over the counter medications such as aspirin:

____

____

Please list all medical conditions, problems, or diseases

____

____

____

I have answered the questions on this form to the best of my knowledg the date indicated:

____

Signature of Responsible Party Date