Medina Orthodontics

Patient Information Form

Patient's Name_____ Date_____
Last First Middle

Address_____
Street City State Zip

Birthdate___/___/___ School _____ Home Phone (___)____-_____

If patient is a minor, name of parent or guardian_____

Whom may we thank for referring you to us?_____

RESPONSIBLE PARTY INFORMATION

Name_____ _____
Last First MI Marital Status

Mailing Address_____
Street City State Zip

How long at this address?_____ Home Ph_____ Work Ph_____

Cell Phone _____ Email address _____

SS#____-____-____ Birthdate ___-___-___Relationship to patient_____

Employer_____ Occupation _____Years employed_____

Spouse's Name_____ Relationship to patient_____

SS#____-____-____ Birthdate___-___-___Employer_____

Occupation_____ Work phone _____ No. Years employed _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ SS#____-____-____

Insurance Company _____Group #_____ Phone #_____

Insurance Company Address_____

Do you have dual coverage? (Two insurances?) _____ Yes _____ No

Secondary Insurance Company Name & Address_____

Group #_____ Telephone #_____

Name & Phone # of nearest relative <u>NOT</u> in your home_____

What are the main concerns that you would like orthodontics to accomplish?

Have you/child been evaluated or had orthodontic treatment before? _____ Y _____N
Has there been any injuries to the face, mouth, teeth or chin? _____ Y _____N
List any musical instruments played: _____
Have adenoids or tonsils been removed? ____Y ____N
Missing/Extra permanent teeth?____Y ____N Pain/Tenderness (TMJ/TMD) ___Y___N
Do you/child brush daily? _____Floss daily? _____ Do gums bleed? ____Y ____N
Physician's Name and Phone Number _____
Are you/child under care of a physician? _____Y _____N Last Visit_____
List all drugs you/child are currently taking_____
List all drugs that you/child are allergic to_____
List Name & Address of General Dentist _____
Phone Number _____
CHILDREN : Has puberty begun? _____Y _____N Menstruation? _____Y _____N
Describe child's physical health _____
WOMEN Are you pregnant?_____ Nursing?_____ Taking oral contraceptives?_____
ADULTS/CHILDREN
Have you/child had any of the following problems? (Circle Y or N)

Y N Abnormal bleeding
Y N Anemia/Radiation treatment
Y N Artificial bones/joints
Y N Asthma/Arthritis
Y N Allergy to plastic/Latex
Y N Blood transfusion
Y N Cancer/Chemotherapy
Y N Fever blisters/Herpes
Y N Shingles
Y N Severe/Frequent headaches
Y N Venereal Disease
Y N Epilepsy/Seizures/Fainting
Y N Ulcers/Colitis
Y N Sinus problems

Y N Diabetes/Tuberculosis
Y N Hearing Impairment
Y N High/Low blood pressure
Y N HIV+/AIDS
Y N Hospitalized for any reason?
Y N Kidney problems
Y N Psychiatric problems
Y N Emphysema/Glaucoma
Y N Drug/Alcohol Abuse
Y N Rheumatic fever? Pre-med Y N
Y N Heart attack/stroke/murmur? Pre-med Y N
Y N Mitral Valve Prolapse? Pre-med Y N
Y N Heart Surgery/Pacemaker? Pre-med Y N
Y N Congenital Heart Defect? Pre-med Y N

Please list any serious medical condition(s)

I understand that the information that I have given today 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 this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or my child) may need during diagnosis and treatment with my informed consent.

I authorize this office to file insurance claims and collect payment according to procedure once treatment begins. I also understand that if my coverage changes or terminates during treatment, I will assume responsibility of the account.

Signature Date