

Patient Information**Welcome****Date:**

Last Name	First Name	Nickname	Sex	Birthdate	Age
Mailing Address	City	State	Zip	Phone	
Employed by/Occupation	Business Phone	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)			
Name Of General Dentist	Who Referred You To Us Or Why Did You Choose Us?				

Parent Information (please complete if patient is a minor)

Father's Name _____	Mother's Name _____
Address (if different from above) Home Phone _____	Address (if different from above) Home Phone _____
SS Number _____	SS Number _____
Employer _____	Employer _____
Business or Cell Phone _____	Business or Cell Phone _____

Information About Person Responsible For This Account

Name	Relationship To Patient	Employed by/Occupation		
Mailing Address	City	State	Zip	Home Phone
Is The Patient Covered by Dental Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Company:	Orthodontic Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide an insurance card for us to copy			Soc Sec Number
If Divorce Is Involved, Who Is The Custodial Parent?	May Patient Information Be Released To The Noncustodial Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Medical History**Dental History**

Please check if patient currently has or has had [Y] [N] <input type="checkbox"/> [] Rheumatic fever <input type="checkbox"/> [] Mitral valve prolapse <input type="checkbox"/> [] Other heart problems <input type="checkbox"/> [] Blood disorders <input type="checkbox"/> [] Chronic headaches <input type="checkbox"/> [] Joint pains	List any other significant medical condition that we should know about:	Please check Yes or No [Y] [N] <input type="checkbox"/> [] Does the patient visit the dentist regularly? Date of last visit _____ <input type="checkbox"/> [] Have their been any injuries to the mouth or teeth? <input type="checkbox"/> [] Thumb, finger, or lip-sucking habits? <input type="checkbox"/> [] Any missing permanent teeth? <input type="checkbox"/> [] Any extra permanent teeth? <input type="checkbox"/> [] Have any teeth been extracted? <input type="checkbox"/> [] Is there any pain or difficulty when chewing? <input type="checkbox"/> [] Has the patient had orthodontic treatment previously? <input type="checkbox"/> [] Has the patient seen another orthodontist?
What orthodontic problems are you aware of? Why is the patient seeking orthodontic treatment?		

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should make payment arrangements and seek reimbursement from the other parent. If a noncustodial parent agrees in writing to make payment arrangements, then statements can be sent to the noncustodial parent.

The initial orthodontic examination in our office is generally done as a courtesy with no fee. If radiographs or other orthodontic records are authorized at that visit or a subsequent visit, appropriate fees will be due. We will file any available dental insurance and make reasonable effort to receive payment. However if insurance benefits are denied or delayed, you will responsible for prompt payment of the fees. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

I give my permission for any photographs, radiographs, or study models to be used in scientific and/or educational presentations.

Signature of Patient or of Parent/Guardian if Patient is a Minor