PRICE ORTHODONTICS AT ROCK RUN

PATIENT INFORMATION

Name_____Date_____

Nickname_____

Birthdate_____/_____/_____Age_____❑ M ❑ F

Address_____

City_____State_____Zipcode_____

Previous address (if less then 3 years)_____

_____

Home Phone_____Wk#_____

Other phone_____Marital Status❑ S ❑ M ❑ D

Email_____

SSN_____DL#_____

Employer_____

Job title_____No of years employed_____

Dentist_____Last visit_____

Favorite Sports or Hobbies_____

Other_____

Incase of Emergency Contact_____

Phone #_____Relationship_____

INSURANCE INFORMATION ❑ YES ❑ NO

Primary Insurance Company_____

Insured Name_____

Contact #_____Group #_____

Subscriber #_____Employer_____

Coverage Amount_____%up to_____max_____deduct

Secondary Insurance Company_____

Insured Name_____

Contact #_____Group #_____

Subscriber #_____Employer_____

Coverage Amount_____%up to_____max_____deduct

REFERRAL

WHO REFERRED YOU TO OUR OFFICE?

❑ Dentist_____

❑ Friend_____

❑ Yellow Pages_____

❑ Other_____

SPOUSE'S INFORMATION

Name_____Birthdate_____

Address_____

City_____State_____Zipcode_____

Home #_____Wk #_____

Employer_____Job title_____

No. of years employed_____Marital Status ❑ S ❑ M ❑

SSN_____DL#_____

PERSON FINANCIALLY RESPONSIBLE

Name_____Birthdate_____

Address_____

City_____State_____Zipcode_____

Home #_____Wk #_____

Employer_____Job title_____

No. of years employed_____Marital Status ❑ S ❑ M ❑ D

SSN_____DL#_____

Orthodontics for kids of all ages!!!

Please complete the Dental and Medical History on the back page
Thank You!

In your words, what is the orthodontic problem?_____

Have you had any previous orthodontic treatment or consultation? ❑ Yes ❑ No

If so, what work was completed, and by whom?_____

Has any other family member had orthodontics?_____

If so, what work was completed and by whom?_____

Were the results acceptable? ❑ Yes ❑ No

Do you now have or have you ever experienced pain or discomfort in your jaw joints? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Do you have any speech problems? ❑ Yes ❑ No

Do you have or have you ever had any thumb or finger sucking habits? ❑ Yes ❑ No

Do you usually breathe through your mouth while awake? ❑ Yes ❑ No

Have you ever experienced an adverse reaction during a medical or dental procedure? ❑ Yes ❑ No

Have you ever received serious trauma or injury to the teeth, face, jaws or head? ❑ Yes ❑ No

Will you best describe the patients attitude toward orthodontic treatment:

❑ Wants treatment ❑ Treatment is necessary ❑ Unwilling, but agrees ❑ Uncooperative

Medical History

Do you have, or have you ever had: ❑ Diabetes ❑ Heart Murmur ❑ Artificial joints or heart valves

Are you under the care of a physician for any specific condition? ❑ Yes ❑ No

If yes, please describe_____

Are you taking any medication? ❑ Yes ❑ No

If yes, please list_____

Please check if you have had any of the following:

❑ AIDS/HIV positive	❑ Convulsions or Epilepsy	❑ Hepatitis
❑ Allergies	❑ Difficulty breathing	❑ Rheumatic/Scarlet fever
❑ Asthma or hayfever	❑ Endocrine or Growth Problems	❑ Tonsillitis
❑ Blood pressure problems	❑ Headaches	❑ Tuberculosis

Authorization

I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate.
I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any changes in my dental or medical status, I will inform Dr. Price.

Signature_____Date_____