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New Patient Form

Patient's Name ____ Date ____________________
Last First Initial

Birthdate ____________________ Age _______ Grade/School _________ Gender M / F SSN#_______-_____-_________

Home Address ____ City ______________ State _____ Zip ____________

Cell # ______________ Cell Phone Carrier ______________ Home # ________________ Work # _________________

Emergency Contact Name ____

Relationship to Patient _______________________ Emergency Contact Number _________________________________

Father's Name ____
Last First Initial DOB Occupation Cell# Work #

Mother's Name ____
Last First Initial DOB Occupation Cell# Work #

Person financially responsible for account ____

Email Address ____

Whom may we thank for referring you to our office? ____

Any other family members seen by us? ____

Primary Dental Insurance		Insurance Phone #	Secondary Dental Insurance		Insurance Phone #
Subscriber's Name (Last, First)		Relationship to Patient	Subscriber's Name (Last, First)		Relationship to Patient
Date of Birth (mm/dd/yyyy)	Social Security Number		Date of Birth (mm/dd/yyyy)	Social Security Number	
Subscriber ID		Group ID	Subscriber ID		Group ID
Employer's Name			Employer's Name		
Employer's Address			Employer's Address		
City	State	Zip	City	State	Zip

Insurance Authorization:
I hereby authorize the doctor or designated staff to release all information necessary to secure the payment of benefits. I accept the responsibility for all fees and services rendered for the treatment of myself and minor(s) whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________	______________________________	________________
Print Name (Primary Insurance holder)	Primary Insurance holder Signature	Date
______________________________	______________________________	________________
Print Name (Secondary Insurance holder)	Secondary Insurance holder Signature	Date

Consent for Treatment:

1. I hereby authorize the doctor or designated staff to perform necessary orthodontic services including but not limited to taking x-rays, administration of anesthetics, study models, photographs, and other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis and treatment of ______________________________________'s (print name of patient) dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agent embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

____	______________________________
Print Name (Patient, or parent if Minor)	Relationship to Patient
____	______________________________
Signature	Date

Medical History

Medical Doctor's Name ________________________________ Phone __________________ Last Visit _____________
Other Contact Information ____

Yes	No		List of medications being taken: _______________
☐	☐	Have you been hospitalized or had a serious illness within the last five years?	____
☐	☐	Are you having any pain or discomfort at this time?	____

Have you had or have at present any of the following:

#	Yes	No	Condition
1.	☐	☐	Heart Disease
2.	☐	☐	High Blood Pressure
3.	☐	☐	Low Blood Pressure
4.	☐	☐	Diabetes
5.	☐	☐	Osteoporosis
6.	☐	☐	Stroke
7.	☐	☐	Seizures
8.	☐	☐	Excessive Bleeding
9.	☐	☐	Anemia
10.	☐	☐	Radiation Treatment
11.	☐	☐	Chemotherapy
12.	☐	☐	Leukemia
13.	☐	☐	Allergies If **yes**, please check the following: ☐ Seasonal: ______________________ ☐ Medications: ____________________ ________________________________ ________________________________ ☐ Latex: _________________________ ☐ Food: __________________________
14.	☐	☐	Hepatitis A/B or Liver Problems
15.	☐	☐	AIDS / HIV
16.	☐	☐	Arthritis, rheumatism
17.	☐	☐	Pacemakers
18.	☐	☐	Prosthetic Heart Valve
19.	☐	☐	Artificial Joints
20.	☐	☐	TMJ Disorder
21.	☐	☐	Sinus Problems
22.	☐	☐	Asthma
23.	☐	☐	Tonsillitis
24.	☐	☐	Ulcers
25.	☐	☐	Tuberculosis
26.	☐	☐	Venereal Disease
27.	☐	☐	Rheumatic Fever
28.	☐	☐	Herpes
Other: ___________________________			

ALL PATIENTS:

#	Yes	No	
29.	☐	☐	Do you have or had any other diseases or medical problems NOT listed in this form. If **yes,** explain: ____
30.	☐	☐	Are you currently taking blood thinners (for example, Aspirin)?

Women:

#	Yes	No	
31.	☐	☐	I am or could be pregnant or nursing.
32.	☐	☐	I am taking birth control pills.

Women taking birth control medications should be aware that antibiotics can cause the birth control medications to possibly be ineffective, resulting in pregnancy.

Dental History

Dentist's Name ________________________________ Phone __________________ Last Visit _____________________
Other Contact Information ____

CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING CONDITIONS:

☐ Bad Breath/Bleeding, Pus, or Swollen Gums	☐ Sensitivity when biting	☐ Food catching between teeth
☐ Loose / Broken / Worn-Out Tooth	☐ Toothaches / Sensitivity to hot & cold	☐ Clenching or Grinding teeth
☐ Difficulty Opening / Closing / Chewing	☐ Last gum treatment date _____________	☐ Popping/Locking or jaw pain

Orthodontic Information

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your primary concern about your teeth? ____
How would you like us to correct the problem? ____
Do you have any concerns about orthodontic treatment? ____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my health status, or if my medication changes, I shall inform the dentist and staff at the next appointment without fail. I understand it is my responsibility to alert my dentist to any medical changes that may or may not have severe effects on the outcomes of my orthodontic treatment.

Information you provide is strictly confidential and will not be released without your permission. I give the office permission to use my photos in the office for publishing in dental journals and for office usage as promotions and on social media. I acknowledge that I have received from the office a copy of the Notice of Privacy Practices.

____   ______________________________
Print Name (Patient, or parent if Minor)   Relationship to Patient

____   ______________________________
Signature   Date