DRAKE ORTHODONTICS

~ PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK ~

Date____/____/____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ Sex ❑ M ❑ F
Last First (Nickname) Middle

Address _____

Home Phone _____ Age _____ Birthday _____ Social Security #_____

Employer/School _____ Grade _____

How did you hear of our office?_____ Dentist _____ Physician _____

Have we seen any other member of your family? If so please list. _____

If patient is a minor with whom does the child reside? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

***All billing will be directed to the custodial parent. It is our office policy not to split accounts for any reason.**

Patient or person responsible for account. _____ Marital Status_____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone_____

How long at this address?_____ Previous Address (if less than 3 yrs.) _____
Street City State Zip

Email Address _____

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation_____ No. Years Employed _____

Responsible Person's Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation_____ No. Years Employed _____

Social Security # _____ Birthday _____ Work Phone _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ and Social Security #_____

Insurance Company_____ Group No._____ Employer_____

Insurance Co. Address_____ Insurance Co. Phone # _____

Do you have dual coverage? Yes ❑ No ❑ If yes please fill out the following:

Policy Holder's Name _____ and Social Security #_____

Insurance Company_____ Group No._____ Employer_____

Insurance Co. Address_____ Insurance Co. Phone # _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment

_____ _____
signed (patient. or parent if minor) Date

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

_____ _____
Signed (Insured Person) Date

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you _____

Complete Address _____

Phone_____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

PATIENT SIGNATURE (Parent's signature if minor) _____

Updates (date & Initial) _____

MEDICAL HISTORY

Is patient in good health? Yes ❑ No ❑ Does patient have any history of major illness: _____ Yes ❑ No ❑

Has patient ever been under the care of a physician for illness? _____ Yes ❑ No ❑

Please list: _____

Check any of the following for which the patient has been treated:

Diabetes ❑	Tuberculosis ❑	Endocrine Problems ❑
Pneumonia ❑	Anemia ❑	Prolonged Bleeding ❑
Heart Trouble ❑	Epilepsy ❑	Fainting or Dizziness ❑
Rheumatic Fever ❑	Asthma ❑	Nervous Disorders ❑
Bone Disorders ❑	Kidney Involvement ❑	Liver Involvement ❑

Does patient have tendency to: Colds ❑ Sore Throats ❑ Ear Infections ❑

Have tonsils and adenoids been removed? What age? _____ Yes ❑ No ❑

List any drugs or medications now being taken, give reasons: _____

_____

List any allergies or drug sensitivity: _____

Has the patient reached puberty? Girls – Has she started menstruation _____ Yes ❑ No ❑

Boys – Has his voice changed _____ Yes ❑ No ❑

Height _____ Weight _____

Hereditary Manifestations: Father's Height _____ Mother's Height _____

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? _____ Yes ❑ No ❑

Has the patient ever sucked a thumb or fingers? Until what age? _____ Yes ❑ No ❑

Does the patient have any speech problems? _____ Yes ❑ No ❑

Is the patient a mouth breather? While awake? Yes ❑ No ❑ While asleep? Yes ❑ No ❑

Have you been informed of any missing or extra permanent teeth? _____ Yes ❑ No ❑

Has an orthodontist been consulted previously? Yes ❑ No ❑ Has either parent had orthodontic treatment? Yes ❑ No ❑

Has the patient had previous orthodontic treatment? Yes ❑ No ❑

Name & address of orthodontist: _____

What were his recommendations? _____

Names and ages of other children in family: _____

List any musical instruments played: _____

Hobbies: _____

Main concern: _____

_____

_____

I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices (HIPAA). A copy of this notice can be obtained from the office of Drake Orthodontics.

I certify that I have read and understand the above. I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand the above information is necessary to provide me with orthodontic care in a safe and efficient manner. I will not hold Drake Orthodontics or the staff responsible for any errors or omissions that I have made in completion of this form.

I give permission for my x-rays, models, and photographs to be used by Drake Orthodontics for the purpose of education, lectures, training, scientific research and promotions.

Patient Signature/(Parent's Signature if minor) _____