Orthodontics
Troy R. Shaw, D.M.D, M.S., P.C.

Member
American Association of
Orthodontists

Practice Limited to Orthodontics
1300 S. Reserve St, Suite C
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Office (406) 327-0777 • Fax (406) 327-8611
www.drtroyshaw.com

CONFIDENTIAL PATIENT INFORMATION

Patient's Name ______________________________ M / F
Last First Middle

Address ______________________________
Street City State Zip

Home Phone ______________ Birthdate ______________ Social Security # ______________

If patient is a minor, give parent's or guardian's name ______________________________

Whom may we thank for referring you to our office: ______________________________

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name ______________________________ Marital Status ______________
Last First Middle

Residence ______________________________ Rent / Own
Street City State Zip

Mailing Address ______________________________ Email ______________

How long at this address ______________ Home Phone ______________ Work Phone ______________

Previous address (if less than 3 yrs.) ______________________________
Street City State Zip

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______________

Spouse's Name ______________________________ Relationship to Patient ______________
Last First Middle

Employer ______________ Occupation ______________ No. Years Employed ______________

Social Security # ______________ Birthdate ______________ Work Phone ______________

INSURANCE INFORMATION

Policy Holder's Name ______________________________ and Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ Union Local No. ______________

Insurance Co. Address ______________________________ Insurance Co. Phone ______________

Policy Holder's Employer ______________________________

Do you have dual coveage? No ☐ Yes ☐ If yes:

Policy Holder's Name ______________________________ and Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ Union Local No. ______________

Insurance Co. Address ______________________________ Insurance Co. Phone ______________

Policy Holder's Employer ______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Phone ______________ Relationship ______________

PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT

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PATIENT

Patient's Name ____
Last   First   Middle

PATIENTS UNDER 18 YEARS OLD

Patient's school ______________________________ Grade __________

Describe patient's temperament ______________________________

Brothers of patient: Ages: (   ) (   ) (   ) Sisters of patient: Ages: (   ) (   ) (   )

What are patient's hobbies and sports? ______________________________

ALL PATIENTS

Who may we thank for referring you to our office? ______________________________

Who noticed the orthodontic problem? Patient ☐ Parent ☐ Dentist ☐

Patient's Dentist ______________________ Patient's Physician ______________________

Date of last visit ______________________ Has Dentist removed any teeth? ______________

Describe orthodontic problem ______________________________

____

What is your main concern regarding this orthodontic problem? Cosmetic ☐ Functional ☐

Have you had any previous orthodontic consultation or treatment? ______________________________

If so, what is your reason for seeking advice or services of another orthodontist? ______________________________

DENTAL/HEALTH HISTORY

	YES	NO
Has either parent had orthodontic care?	☐	☐
Have any siblings had orthodontic care?	☐	☐
Does patient's mouth resemble any other's in family?	☐	☐
Would patient mind wearing braces if necessary?	☐	☐
Is patient aware that treatment success depends on patient cooperation?	☐	☐
Do you anticipate a transfer or move in the near future?	☐	☐

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING?

	YES	NO
Current dental problems?	☐	☐
Unhappy dental experiences?	☐	☐
Teeth grinding/clenching?	☐	☐
Excessive gag reflex?	☐	☐
Mouth breathing?	☐	☐
Thumb/finger sucking?	☐	☐

	YES	NO
Nail biting?	☐	☐
Have tonsils and/or adenoids been removed?	☐	☐
Date removed ______________		
History of injury to face, head or teeth?	☐	☐
Smoking/tobacco use?	☐	☐
History of liver problems?	☐	☐
Hepatitis?	☐	☐
Epilepsy?	☐	☐
Endocrine disorders?	☐	☐
History of heart trouble?	☐	☐
Rheumatic fever?	☐	☐
Heart murmur?	☐	☐
Diabetes?	☐	☐
Bleeding Disorders?	☐	☐
Autoimmune deficiency?	☐	☐
HIV/AIDS?	☐	☐
Tuberculosis?	☐	☐

	YES	NO
Sinus problems?	☐	☐
Radiation treatment?	☐	☐
Tumors/growths?	☐	☐
Drug/alcohol abuse?	☐	☐
Thyroid disease?	☐	☐
Asthma?	☐	☐
Fainting?	☐	☐
Ulcers?	☐	☐
Venereal disease?	☐	☐
Allergies?......Specify: Seasonal/Medical	☐	☐
Is patient under a doctor's care or taking medication?	☐	☐

Other ______________________

Describe any positive responses briefly, include current medications & allergies (use back if necessary) ______

____

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REQUIRED SIGNATURES

I, (responsible party/guardian) hereby authorize this office to release to any company which has issued to me a request for insurance information, all information regarding treatment by this office, and I further assign benefits to this office under said policy, and I further agree to pay this office for any charges for professional services. ______________ INITIAL

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

I authorize the orthodontist and staff to perform necessary services for the above patient. ______________ INITIAL

I am giving my consent for use and disclosure of my protected health information to carry out treatment for payment activities and health care operations. ______________ INITIAL

SIGNATURE ______________________________ DATE ______________

PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT