Patient Information

Patient Name____ Nickname ______________
First Last MI

Patient Address ____
City State Zip

Best Contact Person and Phone Number(s) ______________________ Patient Date of Birth______________

Patient's School______________________ Grade ______________

Does patient have any family members that are current or previous patients at our office? ______________

Who may we thank for referring you to our practice? ______________

Orthodontic Information

Has patient previously been treated with orthodontics? ______________

If yes, please explain ______________

Orthodontic concerns: ______________

Is primary concern functional, cosmetic or both? ______________

Who noticed the orthodontic concern? Patient______ Parent______ Dentist______

Do you expect a transfer/relocation in the near future?______________

Have or will you be seeking the advice or services of another orthodontist? ______________

Dental and Health Information

Patient's Dentist______________________ Month/Year of Last Dental Exam ______________

Did dentist refer patient? Y______ N______ What are your dentist's orthodontic concerns? ______________

DENTAL HEALTH HISTORY			HEALTH HISTORY					
						Cancer	Y	N
Unhappy Dental Experiences	Y	N	Latex Allergy	Y	N	Osteoporosis	Y	N
Gag Reflex	Y	N	Seasonal Allergy	Y	N	HIV	Y	N
Permanent Teeth/Tooth Removal	Y	N	Other Allergy(s): ______________			Radiation Treatment	Y	N
Mouth Breathing	Y	N	______________			Asthma	Y	N
History of Injury to Teeth/Jaws	Y	N	Hepatitis	Y	N	Kidney Problems	Y	N
Thumb/Finger Habit	Y	N	Diabetes	Y	N	Tuberculosis	Y	N
Jaw Pain/Discomfort	Y	N	Heart Murmur	Y	N	Sinus Problems	Y	N
Teeth Grinding/Clenching	Y	N	Bleeding Disorder	Y	N	Other ______________		
Periodontal (gum) Concerns	Y	N	Autoimmune Disorder	Y	N	______________		
			Epilepsy	Y	N			

Please inform us of any medical or dental issues that you would like for us to be aware of. Please be specific:

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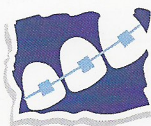
Prescribed Medications:______________



Dr. Troy R. Shaw
Orthodontics

REQUIRED SIGNATURES

Responsible party/guardian ______________

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**________

Periodic visit conversations may be had with person accompanying patient. **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**________

Primary Responsible Party

NOTE: Patients under the age of 18 must be accompanied at their initial examination, financial appointments and treatment review appointments by a parent/legal guardian.

Patient Name ______________________________

Responsible Party Name ______________________________
First *Last* *MI*

Relationship to Patient ____________ *Date of Birth* ____________ *SSN* ____________

Mailing Address ______________________________
City *State* *Zip*

Cell Phone ____________ *Work Phone* ____________ *Other Contact Number* ____________

(This is the number our office will use to contact you.)

Employer ____________ *Occupation* ____________ *No. Years Employed* ____________

Additional Responsible Party

Responsible Party Name ______________________________
First *Last* *MI*

Relationship to Patient ____________ *Relationship to Primary Responsible Party* ____________

Date of Birth ____________ *SSN* ____________

Mailing Address (if different than above) ______________________________
City *State* *Zip*

Cell Phone ____________ *Work Phone* ____________ *Other Contact Number* ____________

Employer ____________ *Occupation* ____________ *No. Years Employed* ____________

Orthodontic Insurance Coverage

NOTE: Please complete only if you have orthodontic coverage. Please provide your card so that we can make a copy for our records.

Policy Holder ____________ *Relationship to Patient* ____________

Insurance Company ____________ *Employer* ____________

GROUP NUMBER ____________ *ID NUMBER* ____________

If we are not able to copy your insurance card, please provide insurance address and phone number ______________________________

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If you have dual insurance coverage please provide our office with all required information for billing and provide primary and secondary coverage information.

EMERGENCY CONTACT

Contact Name: ____________ *Contact Phone Number:* ____________

Relationship to Patient: ______________________________

PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT

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