101 Medical Center Drive Prattville, AL 36066 PHONE (334) 365-2909 FAX (334) 730-0507

WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE.
PLEASE COMPLETE BOTH SIDES OF THIS FORM. ALL INFORMATION IS CONFIDENTIAL. THANK YOU.

PATIENT INFORMATION

DATE: ___________________

PATIENT'S NAME: ____PREFERS TO BE CALLED: ______________________

ADDRESS: ____CITY/STATE/ZIP____

HOME PHONE: ______________________DATE OF BIRTH: _____________AGE_________SEX: MALE / FEMALE SSN:_____________________

SCHOOL: _______________________________________GRADE: ____________E-MAIL: ____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____

NAME AND AGE OF OTHER SIBLINGS: ____

RESPONSIBLE PARTY INFORMATION *(Adult patients, please complete this section)*
NOTE: ***We cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent.***

NAME: ____MARITAL STATUS: ______________ RELATIONSHIP TO PATIENT: _______________

SSN: ________________________DATE OF BIRTH: ___________AGE________ E-MAIL: ____

ADDRESS: ____ HOW LONG AT THIS ADDRESS: _______ OWN / RENT

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS): ____

HOME PHONE: __________________________WORK PHONE: _________________________CELL / PAGER: ______________________________

EMPLOYER: _______________________________OCCUPATION: _____________________________# YEARS EMPLOYED: __________________

SPOUSE'S NAME: ____ RELATIONSHIP TO PATIENT: _______________________________

ADDRESS____CITY/STATE/ZIP____

SSN: ________________________DATE OF BIRTH: ___________AGE_______ E-MAIL: ____

WORK PHONE: ____CELL / PAGER: ____

EMPLOYER: _______________________________OCCUPATION: _____________________________# YEARS EMPLOYED: _________________

*ORTHODONTIC INSURANCE INFORMATION

INSURED'S FULL NAME: ____SSN: ____________________DATE OF BIRTH: ____________________

INSURANCE COMPANY: ________________________ GROUP #: ________________________ CONTRACT/ ID #: __________________________

INSURANCE COMPLETE ADDRESS AND PHONE #: ____

INSURED'S EMPLOYER AND PHONE #:: ____

EMPLOYER'S COMPLETE ADDRESS:____

DO YOU HAVE DUAL COVERAGE? YES / NO IF YES PLEASE FILL IN BELOW

INSURED'S FULL NAME: ____SSN: ____________________DATE OF BIRTH: ____________________

INSURANCE COMPANY: ________________________ GROUP #:_________________________ CONTRACT/ ID #: __________________________

INSURED'S EMPLOYER AND PHONE #: ____

INSURANCE COMPLETE ADDRESS:____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: ____

ADDRESS: ____ PHONE: _______________________________

MEDICAL AND DENTAL HEALTH INFORMATION

PATIENT'S DENTIST: ____ DATE OF LAST DENTAL VISIT: _____________________________

WHAT CONCERNS YOU THE MOST ABOUT YOUR TEETH? ____

HAS AN ORTHODONTIST PREVIOUSLY BEEN CONSULTED? YES / NO

ARE ANTIBIOTICS NECESSARY FOR TEETH CLEANING? YES / NO

IS THE PATIENT ALLERGIC TO LATEX? YES/NO

IS THERE ANY DENTAL WORK THAT NEEDS TO BE COMPLETED PRIOR TO ORTHODONTIC TREATMENT? YES / NO

PATIENT'S PHYSICIAN: ____DATE OF LAST PHYSICAL EXAM: ___________________________

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN AT THIS TIME? YES / NO IF YES, PLEASE EXPLAIN: _________________________

____

LIST ANY MEDICATIONS BEING TAKEN AT THIS TIME: ____

LIST ALL ALLERGIES: ____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL OR DENTAL PROBLEMS?

ABNORMAL BLEEDING	YES / NO	EPILEPSY / CONVULSIONS / SEIZURES	YES / NO	HEADACHES	YES / NO
BONE DISORDERS	YES / NO	AIDS / HIV POSITIVE	YES / NO	SMOKE / CHEW TOBACCO	YES / NO
CANCER OR TUMOR	YES / NO	HEART PROBLEMS	YES / NO	HIGH BLOOD PRESSURE	YES / NO
DIABETES	YES / NO	HEMOPHILIA / PROLONGED BLEEDING	YES / NO	BRUISE / BLEED EASILY	YES / NO
HEPATITIS	YES / NO	TUBERCULOSIS / POSITIVE PPD	YES / NO	PREGNANT NOW	YES / NO
SINUS PROBLEMS	YES / NO	ASTHMA OR HAYFEVER	YES / NO	HEART MURMUR OR MVP	YES / NO
LATEX ALLERGY	YES / NO	ANEMIA	YES / NO	DISABILITIES	YES / NO
PLASTIC / METAL ALLERGY	YES / NO	FINGER / THUMB SUCKING	YES / NO	MOUTH BREATHING	YES / NO
TOOTH / JAW TRAUMA	YES / NO	LIP / TONGUE BITING	YES / NO	TONGUE THRUST	YES / NO
CLENCHING / GRINDING	YES / NO	TONSILS / ADENOID PROBLEMS	YES / NO	SPEECH PROBLEMS	YES / NO
JAW CLICKING / POPPING	YES / NO	ARTHRITIS / OSTEOPOROSIS	YES / NO	PAINFUL JOINTS	YES / NO
CAVITIES NOW	YES / NO	ALCOHOLISM / DRUG ADDICTION	YES / NO	EXTRA TEETH	YES / NO
DENTAL PAIN	YES / NO	FREQUENT COLDS / SORE THROAT	YES / NO	MISSING PERMANENT TEETH	YES / NO
FAINTING OR DIZZINESS	YES / NO	COLD SORES / HERPES	YES / NO	NERVOUS DISORDERS	YES / NO

PLEASE EXPLAIN ANY MEDICAL OR DENTAL PROBLEMS THAT YOU HAVE HAD: ____

____

AFFIRMATION

I AFFIRM THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGES IN MEDICAL STATUS. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED.

____ DATE ____________________________________

PATIENT/PARENT/LEGAL GUARDIAN

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT / PARENT / LEGAL GUARDIAN.

____ ____________________________________

SIGNED DATE