



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.

PATIENT/PARENT/LEGAL GUARDIAN

DATE _____

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

SIGNED

DATE _____