WELCOME TO OUR PRACTICE

Date______________________

Patient's Name____ □ Male □ Female

Patient prefers to be called________________________________Date of Birth_________________________

Address___________________________________City________________State____________ZIP_________

Home Phone:__________________Work Phone___________________Cell Phone_____________________

Spouse________________________Work Phone___________________Cell Phone_____________________

Dentist:_____________________________Whom may we thank for referring you?______________________

Preferred phone number to use when we confirm your appointments_____________________________________

Do you have any insurance that covers orthodontic treatment? □ Yes □ No □ Uncertain

MEDICAL HISTORY

Are you in good health? □ Yes □ No Do you have any history of major illness? □ Yes □ No

Are you currently under the care of a physician for a specific problem? □ Yes □ No

If yes, please explain____

Please list any prescribed medications you are taking at this time_____________________________________

Have you ever been instructed to take antibiotics or any medication prior to any dental work? □ Yes □ No

Please check the following as they apply

□ High Blood Pressure □ Kidney disease □ Heart Trouble

□ Diabetes □ Epilepsy □ Pregnant

□ Arthritis □ Jaw Joint Pain (TMJ/Night Grinding of teeth)

□ Allergies, if yes what?____

DENTAL HISTORY

Have you ever had any injuries to the face, mouth, or teeth? □ Yes □ No

Have you ever had gum disease? □ Yes □ No

Have you ever been informed of any missing or extra permanent teeth? □ Yes □ No

Have you consulted with an orthodontist previously? □ Yes □ No

Has patient or anyone in patient's family had previous orthodontic treatment elsewhere? □ Yes □ No

If so, which family member and where____

Please list any family members treated here and how recently_______________________________________

Please list any other information you feel may be helpful____

Thank-you

____

(Patient's signature)

Emergency Contact Information

If patient is a minor please fill out parent's information, if not please fill out self and spouse's information. If you do not have insurance which would cover orthodontics, please fill out the emergency contact information only.

SELF ____________________

Employer ____________________

Employer's Address ____________________

City ____________ State ____________ Zip ____________

SPOUSE ____________________

Employer ____________________

Employer's Address ____________________

City ____________ State ____________ Zip ____________

Person to notify in case of emergency ____________ Phone ____________

Insurance Information *(if applicable)*

Policy Holder's Relationship to Patient ____________________

Policy Holder's Name ____________________

Policy Holder's Birthday ____________ Policy Holder's ID ____________

Policy Holder's Employer ____________________

Group Policy Number ____________________

Insurance Company ____________________

Insurance Billing Address ____________________

Insurance Phone Number ____________________

Co-Insurance Information *(if applicable)*

Policy Holder's Relationship to Patient ____________________

Policy Holder's Birthday ____________ Policy Holder's ID ____________

Policy Holder's Employer ____________________

Insurance Company ____________________

Group Policy Number ____________________

Insurance Billing Address ____________________

Insurance Phone Number ____________________

In order for us to file your insurance, please sign both of the following statements:

I authorize release of any information relating to this claim. I understand that the estimate of payment is just that, **an estimate**, and I am responsible for all costs not covered by insurance:

____________________ Date: ____________

I authorize payment of the group benefits I am eligible for to go directly to Dr. Randolph J. Hayes.

____________________ Date: ____________