RANDOLPH J. HAYES, JR., D.M.D., M.S.

WELCOME TO OUR PRACTICE

Date:_____

Patient's Name:_____ □ Male □ Female

Patient prefers to be called:_____ Date of Birth:_____

Father's name:_____ Mother's name:_____

Father's work number:_____ Mother's work number:_____

Patient lives with:_____ Home Phone:_____

Address:_____ City:_____ State:_____ ZIP:_____

Name of person responsible for account:_____ Daytime phone:_____

Address:_____ City:_____ State:_____ ZIP:_____

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

Is patient in good health? □ Yes □ No Does patient have history of major illness? □ Yes □ No

Is patient currently under the care of a physician for a specific problem? □ Yes □ No

Has patient ever been informed they have an allergy to latex or nickel □ Yes □ No

If yes, please explain:_____

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

Please list any prescribed medications patient is taking at this time:_____

Father's height:_____ Mother's Height:_____ Patient's Height:_____

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

_____

(Parent or Legal Guardian'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.

FATHER

Employer

Employer's Address

City State Zip

MOTHER

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: