Patient Information

Date___________________________

Patient's Name____Birthdate______________________

Home Phone________________________ Cell Phone_________________________ Work Phone ________________________

Email address____

Address____

Whom may we thank for referring you to our office? ____

Responsible Party Information

Name____Birthdate______________________

Home Phone________________________ Cell Phone_________________________ Work Phone ________________________

Home Address____How long________

Marital Status ____________________Relationship to Patient_______________________ SS#________________________

Employer_________________________________ Occupation______________________ # of years employed ____________

Name____Birthdate______________________

Cell Phone ______________________ Relationship to Patient_______________________ SS#________________________

Employer_________________________________ Occupation______________________ # of years employed ____________

Dental Insurance Information

Insurance Company __________________________________ Telephone #___________________ Group#________________

Ins. Comp. Address____

Insured's Name____Birthdate__________________________

Relation_________________________ SS#/I.D.# _________________________ Employer______________________________

Secondary Ins. Comp. _______________________________ Telephone #____________________ Group#________________

Ins. Comp. Address____

Insured's Name____Birthdate__________________________

Relation_________________________ SS#/I.D.# _________________________ Employer______________________________

Emergency Information

Name of nearest relative not living with you____

Complete Address____

Phone #____ Relationship____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ____

DENTAL HISTORY

Dentist's Name_______________________________________Date of last dental visit_______________

Check if you have had any of the following:

- □ Bleeding gums
- □ Clicking or popping of jaw
- □ Food collection between teeth
- □ Grinding teeth
- □ Periodontal treatment
- □ Sensitivity to cold
- □ Sensitivity to heat
- □ Sensitivity to sweets
- □ Sensitivity when biting

MEDICAL HISTORY

Physician's Name_______________________________________Date of last visit___________________

Are you under medical treatment now? □ Yes □ No

Have you had any serious illness or operations? □ Yes □ No If yes, describe_________________________

Are you taking any medications? □ Yes □ No If yes, what are they?_________________________________

Do you have any allergies? □ Yes □ No If yes, what are they?_____________________________________

Women only: Are you pregnant? □ Yes □ No

Check if you have had any of the following:

- □ AIDS
- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Cortisone Treatment
- □ Cough (Persistent)
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problems
  Describe___________
- □ Hemophilia
- □ Hepatitis
- □ High Blood Pressure
- □ HIV Positive
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Nervous Problems
- □ Pace maker
- □ Psychiatric Care
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet/Ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

AUTHORIZATION, RELEASE AND CONSENT

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the orthodontist benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

This is to verify that I hereby authorize Dr. Brian K. Bons and his assistants to perform whatever examination and treatment is deemed necessary and that the medical history I have given is correct.

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Signature of patient or parent if minor Date