



Name _____ Preferred Name _____ Age _____

Male Female DOB _____ Social Security # _____

Home Address _____ City _____ Zip _____

Home Phone # _____ E-mail _____ Cell # _____

Employer _____ Employers Phone# _____

Dentist Name _____ Last Visit _____

Who can we thank for referring you to our office? _____

Internet Yellow Pages Front Sign Flyer Other _____

Do you have orthodontic Insurance? Yes No

If yes, who is the Primary Subscriber? _____ DOB _____

Subscriber's Social Security # _____ Employer _____

Name of Insurance _____ Insurance Phone # _____

For Secondary Coverage only:

Name of Secondary Subscriber? _____ DOB _____

Subscriber's Social Security # _____ Employer _____

Name of Insurance _____ Insurance Phone # _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

- | | | |
|--|--|--|
| <input type="checkbox"/> Jaw Joint Problems | <input type="checkbox"/> Head or Facial Injuries | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Endocrine Disorder |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other, Please Explain _____ |

Are you under the care of a physician at the present time? No Yes If yes, Please explain _____

Dental History

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

Explain _____

Have you had any TMJ (Jaw joint) problems? No Yes If yes, Explain _____

Have you ever had any periodontal Disease? No Yes, If so, by whom? _____

What part of your orthodontic problems concerns you the most? _____

Is there any additional information that you feel we need in order to make this a more enjoyable experience?

Yes No _____

Thank you!

Signature _____ **Date** _____

TO BE SIGNED AT APPOINTMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received a copy of this notice of privacy practices.

Please Print Name _____

Signature _____ Date _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but could not be obtained because:

Individual refused to sign

Communication barriers prohibited the acknowledgment

An Emergency situation prevented us from obtaining the acknowledgment

Other (please specify) _____