Welcome to our orthodontic office

(Please fill out this form completely)

Patient Information

Today's Date: _____ E-mail Address:_____

Name:_____ Age____ Birthdate ___/ ____/____ □Male □ Female

Home Address:_____
Street City State Zip

Home Phone: (____)_____ Cell Phone: (___)_____

General Dentist:_____ Referred By:_____

Responsible Party

Name:_____ Relation: □ Mom □Dad □Spouse □ Self □ Other

Address:

_____
Street City State Zip

Home Phone: (___)_____ Cell Phone: (___)_____

Name: _____ Relation: □ Mom □Dad □Spouse □ Self □ Other

Address:

_____
Street City State Zip

Home Phone: (___)_____ Cell Phone: (___)_____

Insurance Information

Primary Insurance

Insurance Co. Name:_____ Phone #:(____)_____

Insurance Co. Adress:_____
Street /P.O. Box City State Zip

Insured's Name:_____ Insured's Social Security: _____

Insured's Birthdate :___/____/____ Relation :_____ Group/Id #:_____

Insured's Employer: _____ Employer's Address:_____

Secondary Insurance

Insurance Co. Name:_____ Phone #:(____)_____

Insurance Co. Address:_____
Street /P.O. Box City State Zip

Insured's Name:_____ Insured's Social Security: _____

Insured's Birthdate :___/____/____ Relation :_____ Group/Id #:_____

Insured's Employer: _____ Employer's Address:_____

Continue on Back

Are you currently under the care of a physician? □ **Yes** □ **No**
Please explain:

_____

Physician Name: _____Phone # :_____
Address:_____
Have you ever had any major surgery, illness, or ever been hospitalized? □ **Yes** □ **No**
If so, Please explain:_____
Are you currently taking any medications? □ **Yes** □ **No**
If so, please list_____
For Women: Are you pregnant ? □ **Yes** □ **No** □ **Unsure**
Are you taking birth control pills ? □ **Yes** □ **No**
Are you allergic to :
Penicillin or other antibiotics □ **Yes** □ **No**
Aspirin □ **Yes** □ **No**
Latex □ **Yes** □ **No**
Other:_____

Do you or have you experienced the following?

	YES	NO
Rheumatic Fever or Rheumatic Heart Disease……	____	____
Congenital heart lesions or murmur ……	____	____
Cardiovascular disease (high blood pressure, heart attack, stroke, etc…)……..	____	____
Damaged or artificial heart valves……..	____	____
Asthma……	____	____
Hay fever……	____	____
Fainting or seizures ……	____	____
Diabetes……	____	____
Hepatitis, jaundice, or liver disease……	____	____
Kidney trouble……	____	____
Tuberculosis……	____	____
Blood disorder ……	____	____
Prosthetic joints, implants, screws, plates……	____	____
Have you ever tested positive for the HIV antibody or been diagnosed with AIDS or an AIDS related complex?……	____	____
Do you have any disease, condition, or problem not listed you think I should know about?……	____	____

If so, please explain:_____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes. I authorize the office dental staff to perform the necessary services that my child may need. I assign Dr. Bauer all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible and co-payments that my insurance does not cover.

Signature **Date**

Reviewed by: _____ _____
Doctor Signature **Date**

Medical History Updates

	Date	Changes	
	Patient's signature		**Doctor signature**
_____	_____	_____	_____
_____	_____	_____	_____