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

☐Jaw Joint Problems
☐Heart Problems
☐Kidney Problems
☐Liver Disease
☐High Blood Pressure
☐Pregnancy
☐Congenital Heart Conditions

☐Head or Facial Injuries
☐Ear Infections
☐Allergies
☐Diabetes
☐Bleeding Disorder
☐Asthma

☐Epilepsy
☐Speech Problems
☐Endocrine Disorder
☐Nervous Disorder
☐Rheumatic Fever
☐Artificial Joints
☐ 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

<u>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</u>

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

Please Print Name____

Signature __________________________________Date ______________________________________

<u>For office use only</u>

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)____