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Patient Information

Patient's Name: _____ Male Female
First Middle Last

Date of Birth: ____ / ____ / ____

Address: _____
Street Town State Zip

If Patient is a minor, give parent's/guardian's name(s): _____

Names/Ages of brothers and sisters: _____

Responsible Party Information

Name: _____ Married Divorced Single
First Middle Last Marital Status

Custodial Parent: Mother Father Both E-Mail Address: _____

Address: _____
Street Town State Zip

How long at this address? _____ Home Phone: (____) _____ Work Phone: (____) _____

Previous Address (if less than 3 yrs.) _____
Street Town State Zip

Social Security #: _____ Date of Birth: ____ / ____ / ____ Work Phone (____) _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____
First Middle Last

Employer: _____ Occupation: _____ No. Years Employed: _____

Social Security #: _____ Date of Birth: ____ / ____ / ____ Work Phone: (____) _____

Dental Insurance Information

<u>Primary</u>	<u>Secondary</u>
Policy Holder: _____	Policy Holder: _____
SS# of Policy Holder: _____	SS# of Policy Holder: _____
Policy Holder's Date of Birth: ____ / ____ / ____	Policy Holder's Date of Birth: ____ / ____ / ____
Insurance Company: _____	Insurance Company: _____
Insurance Address: _____	Insurance Address: _____

Insurance Group/Policy#: _____ Insurance Group/Policy#: _____

- I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Island Orthodontics of the insurance benefits otherwise payable to me.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
- I certify that the above information is complete and true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor): _____ Date: ____ / ____ / ____

Patient's Medical/Dental History

Patient's Dentist: _____ Phone#: (____) _____ Last Visit: _____

What is patient's/parent's primary concern: _____

Patient's Physician: _____ Phone#: (____) _____ Last Visit: _____

Is patient presently being treated by a physician? Yes No Why?: _____

Has the patient's tonsils and adenoids been removed? Yes No Is child adopted? Yes No

Has the patient ever had an unusual reaction to any drug? Yes No Is child aware of adoption? Yes No

Does patient have a speech problem, if so are they receiving therapy? Yes No

Has the patient any of the following?

- Heart Murmur
- Rheumatic Fever
- Mitral Valve Prolapse
- Pre Medication Required
- Anemia
- Bleeding Problems
- Gum Problems
- Tuberculosis
- Diabetes
- Epilepsy
- Convulsions/Seizures
- Immune Deficiency
- Smoke Cigarettes/Cigars
- Asthma
- Breathing Problems
- Frequent Colds
- Sinus Problems
- Cold Sores
- ADD/ADHD
- Ulcers
- Thyroid/Hormonal Imbalance
- Lip Biting
- Nail Biting
- Tongue Thrusting
- Presently Suck Thumb/Finger
- Arthritis
- Problems Opening/Closing
- Chewing Problems
- Jaw Popping
- Grinding/Clenching
- Concussion
- Injury to Teeth/Jaws
- Severe Headaches
- Facial Pain
- Any TMJ History
- Nervous Disorder
- Hearing Problem
- Latex Allergy
- Metal Allergy
- Seasonal Allergy
- Other Allergy: List: _____
- Major Surgery

Has Patient ever had orthodontic treatment or worn a retainer? Yes No

Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: _____

If Female: Menstruating? Yes No Date of First Period: ___/___/___

If Male: Voice Change? Yes No Date Started: ___/___/___ Shaving? Yes No Date Started: ___/___/___

Names of Daily Medications? _____

Is there any other information about the patient's health we should know? _____

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

Please circle all that apply:

My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List

Island Orthodontics Website Invisalign Website Yellow Page Ad Newspaper Ad in: _____

My Friend/Relative Referred Me (list name(s)): _____

Other (please specify): _____

Signature (Parent's if minor): _____ Date: ___/___/___

Review by Doctor: _____ Date: ___/___/___