KBL ORTHODONTICS

<u>ORTHODONTIC PATIENT INFORMATION</u>

PATIENT'S NAME: **NICKNAME:**

DATE OF BIRTH: **AGE:**   **GENDER:**

ADDRESS:

HOME PHONE: **E-MAIL:**

CELL PHONE: **CELL PHONE CARRIER:** _____

SCHOOL: _____ **GRADE:** _____

SPORTS/HOBBIES: _____

Father's Name: _____ **Phone#:** _____

Father's Employer: _____ **Social Security#:** _____

Mother's Name: _____ **Phone#:** _____

Mother's Employer: _____ **Social Security#:** _____

PATIENT LIVING WITH: ☐ **Parents**   ☐ **Mother**   ☐ **Father**   ☐ **Other**

Emergency Contact Name: _____

Emergency Contact Phone#: _____ **Relationship:** _____

GENERAL DENTIST:

REFERRED BY:

RESPONSIBLE PARTY NAME: _____

                    ADDRESS: _____

Is patient covered by insurance for orthodontic treatment?   ☐ YES   ☐ NO

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

_____   _____

Signature   **Date**

MEDICAL HISTORY

Physician:_____   Date of Last Visit:_____
Address:_____   Phone:_____

Please circle Yes or No (If Yes, please fill in details)

Yes   No   Are you taking any medication?_____
Yes   No   Are you allergic to any medication?_____
Yes   No   Do you have a history of a major illness?_____
Yes   No   Have you had any operations?_____
Yes   No   Have you ever smoked or chewed tobacco?_____
Yes   No   Have seen a physician in the last 12 months? Why?_____
Yes   No   Female Patient Only: Has Menstruation started?_____   Are you preganant:_____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Hemophilia
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorder	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware
of?_____

DENTAL HISTORY

General Dentist:_____   Date of last visit:_____
What concerns you most about your teeth?_____

Yes   No   Are you presently in any dental pain?_____
Yes   No   Have you ever experienced any unfavorable reaction to dentistry?_____
Yes   No   Have you ever lost or chipped any teeth?_____
Yes   No   Have there been any injuries to face, mouth, or teeth?_____
Yes   No   Is any part of your mouth sensitive to temperature/pressure? Where?_____
Yes   No   Do you have any type of thumb or tongue habit?_____
Yes   No   Have you ever seen an orthodontist? If yes, who and when?_____
Yes   No   Has anyone in your family received orthodontic treatment?_____
Yes   No   Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____
Yes   No   Are you aware of your jaw clicking or popping?_____
Yes   No   Are you aware of clenching your teeth during the day?   _____
Yes   No   Have you ever been told that you grind your teeth?_____
Yes   No   Have you ever experienced chronic ringing in your ears?_____
Yes   No   Are you aware that some appointments will be during work hours?

Doctor's Signature_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____   to perform a complete orthodontic evaluation.

Signature:_____   Date:_____

KBL
ORTHODONTICS

ORTHODONTIC INSURANCE INFORMATION

PATIENT NAME: DOB:

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S ADDRESS: _____

_____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

SUBSCRIBER'S DATE OF BIRTH: _____

INSURED'S EMPLOYER: _____ GROUP#:_____

NAME OF INSURANCE COMPANY:_____

POLICY/CONTRACT#:_____

INSURANCE CO MAILING ADDRESS: _____

_____

INSURANCE CO TELEPHONE #: _____

<u>OFFICE USE ONLY:</u>
IN ORDER TO PROCESS YOUR INSURANCE EFFECTIVELY, WE WILL CONTACT YOUR INSURANCE COMPANY AND OBTAIN THE FOLLOWING INFORMATION FOR <u>ORTHODONTIC BENEFITS:</u>

PERCENTAGE COVERED _____% LIFETIME MAX:_____
AGE LIMIT:_____
EFFECTIVE DATE: _____ WAITING PERIOD: Y/N
DEDUCTIBLE: $_____ CHECKS PAYABLE TO:_____
PREVIOUS BENEFITS PAID): $_____ REMAINING BENEFITS: $_____
PRE-AUTHORIZATION REQUIRED: Y/N QUARTERLY VERIFICATION: Y/N

I hereby authorize release of any information relating to this and any claim and payment directly to the above named orthodontist of the insurance benefits.

SIGNATURE: _____