

PATIENT INFORMATION

FIRST _____ MI _____ LAST _____ DOB: ____/____/____
 ADDRESS: _____ CITY/STATE/ZIP _____ Pt. Phone: (____) ____-____

PARENT INFORMATION (If patient <18 y/o) *

RESPONSIBLE PARTY INFORMATION

Mother's Name: _____	PERSON RESPONSIBLE FOR ACCOUNT (signed contract)
Employer: _____	Name: _____
Occupation: _____	Address: _____
MARITAL STATUS <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> other	City: _____ State: _____ Zip: _____
Father's Name: _____	SS#: _____ - _____ - _____
Employer: _____	DOB: ____/____/____ SEX: _____
Occupation: _____	Home phone: (____) _____ - _____
MARITAL STATUS <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> other	Work phone: (____) _____ - _____
How did you hear about our office? _____	Cell phone: (____) _____ - _____
Is your family new to our practice? _____	Email Address _____@_____
	Names of family members: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____	Policy Holder's NAME: _____
Insurance Phone: (____) _____ - _____	Policy Holder SS#: _____ - _____ - _____
Employer: _____	Policy Holder DOB: ____/____/____
	Group #: _____

Patient relation to Policy Holder: **CHILD / SELF / SPOUSE** (CIRCLE ONE)

SECONDARY INSURANCE INFORMATION

Insurance Company: _____	Policy Holder's NAME: _____
Insurance Phone: (____) _____ - _____	Policy Holder SS#: _____ - _____ - _____
Employer: _____	Policy Holder DOB: ____/____/____
	Group #: _____

Patient relation to Policy Holder: **CHILD / SELF / SPOUSE** (CIRCLE ONE)

Patient Authorization

____ **Consent to use of Records:** I hereby give my permission for the use of orthodontic records for purpose of professional consultations, research, education, or publication in professional journals.

____ **Authorization to release information:** I hereby authorize the release of any medical information necessary to process all claims for charges incurred at Roth Orthodontics

____ **Financial Agreement:** I assign payment directly to Roth Orthodontics for the dental benefits, if any, otherwise payable to me for services as described above but not to exceed my indebtedness to Roth Orthodontics for those services. I agree that I am financially responsible for all charges not covered by my insurance company, included but not limited to dental services deemed routine, elective or not medically necessary by my insurance company and/or any co-pays, deductibles, co-insurance amounts or non-covered items specified by my insurance company.

____ **Note to Privacy Practices:** I acknowledge that I have read and understood the content of the Notice of Privacy Practices.

Parent/Guardian Signature _____ Date: _____

MEDICAL HISTORY

Are you taking any medication, have any allergies, or have a history of major illnesses? Yes No
 Have you ever taken Fosomax®, Bis-phosphonates, or steroids? Yes No

If Yes, please fill in details: _____

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

- | | | | |
|--------------|----------------------------|---------------------|---------------------------|
| Allergies | Hepatitis/Liver problems | Pneumonia | Tumor or Cancer |
| Anemia | Hemophilia | Dizziness | Prolonged Bleeding |
| Arthritis | Asthma or Hayfever | High Blood Pressure | Radiation / Chemotherapy |
| Epilepsy | Gastrointestinal Disorders | HIV+ / Aids | Rheumatic / Scarlet Fever |
| Tuberculosis | Congenital Heart Defect | Bone Disorders | Heart Problems |
| Heart Murmur | Kidney problems | Diabetes | Nervous Disorders |

Are there any medical conditions we have not discussed that you feel we should be aware of? Yes No

If Yes, please fill in details: _____

DENTAL HISTORY

General or Pediatric Dentist: _____ Date of last visit: _____

What are the main concern(s) you would like orthodontics to accomplish? _____

Do you feel your teeth are (circle all responses that apply):

- | | |
|--------------------------------------|------------------------------------------------------------------|
| Too small or short? Yes No | Sticking out too far? Yes No |
| Too large or long? Yes No | Set back too far? Yes No |
| Crooked or crowded? Yes No | Spaced out too much? Yes No |
| Misshaped (uneven / pointed)? Yes No | Showing too much or too little gum tissue when you smile? Yes No |
| Off color? Yes No | |

- Are you presently in any dental pain? Yes No
 Have there been any injuries to face, mouth or teeth? Yes No
 Is any part of your mouth sensitive to temperature or pressure? Yes No
 Do your gums bleed when you brush? Yes No
 Do you have any current type of thumb habit? Yes No
 Do you have any current type of tongue habit? Yes No
 Are you a mouth breather? 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
 Do you have frequent headaches? Yes No
 Have you ever experienced chronic ringing in your ears? Yes No
 Are you aware that some appointments will be during school/work hours? Yes No

Female Patients Only

Are you pregnant or currently trying to get pregnant? Yes No

Has anyone in your family received orthodontic treatment? Yes No
 How did they feel about the result? _____

Has the patient ever seen an orthodontist? If yes, who and when? Yes No
 Who? _____ When? _____

What is your attitude toward receiving braces? Excellent OK Indifferent Unhappy
 What is your attitude toward receiving Invisalign®? Excellent OK Indifferent Unhappy

I have completed this information in the fullest extent possible and authorize the Roth Orthodontics staff to perform a complete orthodontic evaluation based on this information. I hereby give my permission for the use of orthodontic records for purpose of professional consultations and I acknowledge that I have read and understood the content of the Notice of Privacy Practices.

Patient / Guardian Signature: _____ Date: _____