# CONFIDENTIAL PATIENT INFORMATION

| | | |
|---|---|---|
| **Patient Name** | DOB | Sex: Male Female |
| Address | City | State Zip |
| Home Phone Cell Phone | | Email |
| Whom may we thank for referring you to our office? | | |
| If patient is a minor, give parent or guardian name | | |

**FINANCIAL RESPONSIBLE PARTY INFORMATION**

| **Name:** | **Name:** |
|---|---|
| Relationship to patient | Relationship to patient |
| Social Security No. DOB | Social Security No. DOB |
| Home Phone Cell Phone | Home Phone Cell Phone |
| Email Address | Email Address |
| Home Address | Home Address |
| City State Zip | City State Zip |
| How long at this address? Own Rent<br>Previous address (if less than three years) | How long at this address? Own Rent<br>Previous address (if less than three years) |
| Employer | Employer |
| Occupation Years Employed | Occupation Years Employed |

**DENTAL INSURANCE INFORMATION**

***Please note that services are covered under your ***dental*** plan not your ***medical*** plan

| **Primary Dental Insurance Information:** | **Secondary Dental Insurance Information:** |
|---|---|
| Policy Holder's Name | Policy Holder's Name |
| Relationship to patient | Relationship to patient |
| DOB ID No. | DOB ID No. |
| Insurance Co. Name | Insurance Co. Name |
| Insurance Co. Address | Insurance Co. Address |
| Insurance Co. Phone | Insurance Co. Phone |
| Policy Holder's Employer | Policy Holder's Employer |

**AUTHORIZATION and PRIVACY NOTICE**

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Furthermore, I acknowledge that I have been provided with a notice of PRIVACY POLICIES by Easton Orthodontic Associates.

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

X

| | | |
|---|---|---|
| Signature (Parent or Guardian's signature if minor) | Print Name | Date |

**CONFIDENTIAL PATIENT INFORMATION**

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|---|
| Patient Name I prefer to be called |
| If minor child, attends school at |
| Musical instruments played |
| Sports/Hobbies |
| If minor child, please list any siblings name and age |
| Other family members treated here |
| What is your primary concern? Why are you here? |
| Is patient sensitive or self-conscious about teeth? |
| Who suggested that you or your child might need orthodontic treatment? |
| Why did you select our office? |
| Name of patient's physician Phone No. |
| Physician's address |
| Date last seen Reason for visit |

**MEDICAL HISTORY**

| **Now or in the past, has the patient had:** | Yes | No | **Allergies or reactions to any of the following:** |
|---|---|---|---|
| Birth defects or hereditary problems | | | Penicillin or other antibiotics Yes No |
| Bone fracture, any major accidents | | | Latex (gloves, balloons) Yes No |
| Rheumatoid or arthritic conditions | | | Foods (specify) |
| Endocrine or thyroid problems | | | Other substances (specify) |
| Kidney problems | | | Are you currently taking medication? Please name them: |
| Diabetes | | | |
| Cancer, tumor, radiation treatment or chemotherapy | | | **Does patient need pre-med with antibiotic for dental procedures?** Yes No |
| Stomach ulcer | | | |
| Polio, mononucleosis, tuberculosis, pneumonia | | | Does patient currently have or ever had a substance abuse problem? Yes No |
| Problems of the immune system | | | Does the patient chew or smoke tobacco? Yes No |
| AIDS or HIV positive | | | Surgeries? Describe |
| Hepatitis, jaundice or liver problem | | | Hospitalized? Describe |
| Fainting spells, seizures, epilepsy, or neurological problem | | | Other physical problems or symptoms? Describe |
| Mental health disturbance or depression | | | Being treating by another health care professional? |
| Vision, hearing, tasting or speech difficulties | | | Describe: |
| Loss of weight recently, poor appetite | | | |
| History of eating disorder (anorexia, bulimia) | | | Date of most recent physical exam? |
| Excessive bleeding or bruising tendency, anemia or bleeding disorder | | | Are there any other medical conditions that we should be aware of? |
| High or low blood pressure | | | Describe: |
| Cardiovascular problem (heart trouble, heart attack, angina, arteriosclerosia, stroke, heart murmur or rheumatic heart disease | | | **FEMALES ONLY WHEN APPLICABLE:**<br>Has menstruation started? If so, when? _____<br>Is the patient pregnant? Yes No |
| Eye, ear, nose or throat condition | | | |
| Hayfever, asthma, sinus, or hives | | | |
| Tonsil or adenoid condition | | | |

**CONFIDENTIAL PATIENT INFORMATION**

| | |
|---|---|
| Patient Name | |
| Name of Patient's Dentist | Phone No. |
| Dentist's Address | |
| Date Last Seen | Reason |

**DENTAL HISTORY**

| **Now or in the past, has the patient had:** | **Yes** | **No** | | **Yes** | **No** |
|---|---|---|---|---|---|
| Started teething very early or late? | | | Any pain in jaw or ringing in the ears? | | |
| Primary (baby) teeth removed that were not loose? | | | Any pain or soreness in the muscles of the face or or around the ears? | | |
| Permanent or "extra" (supernumerary) teeth removed? | | | Difficulty encountered in chewing or jaw opening? | | |
| Supernumerary (extra) or congenitally missing teeth? | | | Aware of loose, broken or missing restorations (fillings)? | | |
| Chipped or otherwise injured primary (baby) or permanent teeth? | | | Any teeth irritating cheek, lip, tongue or palate? | | |
| Teeth sensitive to hot or cold; teeth throb or ache? | | | Concerned about spaced, crooked or protruding teeth? | | |
| Jaw fractures, cysts or mouth infections? | | | Aware or concerned about under or over developed jaw? | | |
| "Dead teeth" or root canals treated? | | | Any relative with similar tooth or jaw relationships? | | |
| Bleeding gums, bad taste or mouth odor? | | | Had periodontal (gum) treatment? | | |
| Thumb, finger, or sucking habit? Until what age? | | | Any serious trouble associated with any previous dental treatment? | | |
| Abnormal swallowing habit (tongue thrusting)? | | | Ever had a prior orthodontic exam or treatment? Specialist name: | | |
| History of speech problems? | | | Been under another dental specialist's care? Specialist name: | | |

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

| | |
|---|---|
| Signature (Parent or Guardian) | Date |
| Signature (Dental Staff Member) | Date |