**PATIENT INFORMATION**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_M \_\_\_F SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_\_**

**Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONSIBLE PARTY INFORMATION**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE INFORMATION**

**Insured’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_**

**Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Policy #\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Co Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insured’s Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

**Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insured’s Employer Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY INSURANCE INFORMATION** (if applicable)

**Insured’s Name (Full Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insured’s SSN: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_**

**Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Policy #\_\_\_\_\_\_\_\_\_\_\_   
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Co Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insured’s Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY INFORMATION**

**Name of Emergency Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE CIRCLE Yes or No (If Yes, please fill in details.)**

**Yes No Are you in good health?   
Yes No Have you ever had a health problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Have you ever been hospitalized or had any major operations? If Yes, please give reason and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Are you taking any medications?   
Please give medication name, dose and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Are you allergic to any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Do you have a history of a major illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Have you ever been involved in a serious accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE MARK if you have or have been treated for any of the medical conditions/health issues and elaborate below:**

|  |  |  |
| --- | --- | --- |
| **\_\_Abnormal Bleeding**  **\_\_ADD/ADHD**  **\_\_Adverse Drug Reactions**  **\_\_Anemia**  **\_\_Arthritis**  **\_\_Asthma/Hay Fever**  **\_\_Autism**  **\_\_Bleeding/Transfusions**  **\_\_Blood Disorder**  **\_\_Bone Disorders**  **\_\_Cancer/Tumor**  **\_\_Cerebral Palsy**  **\_\_Cleft lip/palate**  **\_\_Congenital Heart Defect**  **\_\_Diabetes** | **\_\_Dizziness**  **\_\_Endocrine/Growth**  **\_\_Epilepsy**  **\_\_Eyesight**  **\_\_Frequent Infections**  **\_\_GI Disorders**  **\_\_Heart Problems**  **\_\_Hepatitis**  **\_\_Heart Disease**  **\_\_Heart Murmur**  **\_\_HIV/Aids**  **\_\_High Blood Pressure**  **\_\_Kidney Problems/Disease**  **\_\_Herpes**  **\_\_Liver Problems** | **\_\_Mental Delays \_\_Neuromuscular Disorder**  **\_\_Nervous Problems**  **\_\_Personality/Social**  **\_\_Physical Delays**  **\_\_Pneumonia**  **\_\_Recurrent Headaches**  **\_\_Rheumatic Fever**  **\_\_Prolonged Bleeding**  **\_\_Radiation/Chemotherapy**  **\_\_Seizures**  **\_\_Sickle Cell Disease/Trait**  **\_\_Significant Injuries**  **\_\_Speech/Hearing** |

**Details on any checked item: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are there any other medical conditions not listed that we should be aware of?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DENTAL HISTORY**

**Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last x-rays (if taken): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Have you experienced any unfavorable reaction from previous dental care?**

**Yes No Do you have pain with chewing, yawning, or wide opening of his/her mouth?**

**Yes No Does your jaw make noise and is pain associated with the sounds?**

**What concerns you most about your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Are you presently experiencing any dental pain? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Have you ever lost or chipped any teeth?**

**Yes No Have there been any injuries to your 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 type of thumb or tongue habit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No Are you a mouth breather?**

**Yes No Have you ever seen an orthodontist?**

**AUTHORIZATION & RELEASE**

* **I have read and answered the above questions to the best of my knowledge.**
* **I authorize my insurance company to pay Chattahoochee Family Orthodontics all insurance benefits otherwise payable to me for services rendered.**
* **I authorize the use of this signature on all insurance submissions.**
* **I authorize Chattahoochee Family Orthodontics 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.**

**Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date: \_\_\_\_\_\_\_\_\_\_**

**PHOTO &VIDEO RELEASE**

**I hereby give permission for images of me captured during any/all Chattahoochee Family Orthodontics visits or activities of events through video, photo and digital camera, to be used solely for the purposes of Chattahoochee Family Orthodontics promotional material and publications and waive any rights of compensation or ownership thereto.**

**Name of Participant (Please print.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**