MILLER ORTHODONTICS

ORTHODONTIC PATIENT INFORMATION

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:_____

MILLER 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 #: _____

OFFICE USE ONLY:

IN ORDER TO PROCESS YOUR INSURANCE EFFECTIVELY, WE WILL CONTACT YOUR INSURANCE COMPANY AND OBTAIN THE FOLLOWING INFORMATION FOR *ORTHODONTIC BENEFITS*:

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: _____