Welcome to our Practice!

PATIENT INFORMATION

Today's Date: _____

Patient's Full Name: _____ Patient's Date of Birth: ____ /____ / _____

Address: _____ City_____ Zip_____

Primary Phone #: _____**Email Address:** _____

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: _____
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, foods, or other? _____

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	**__Dizziness**	**__Mental Delays**
__ADD/ADHD	**__Endocrine/Growth**	**__Neuromuscular Disorder**
__Adverse Drug Reactions	**__Epilepsy**	**__Nervous Problems**
__Anemia	**__Eyesight**	**__Personality/Social**
__Arthritis	**__Frequent Infections**	**__Physical Delays**
__Asthma/Hay Fever	**__GI Disorders**	**__Pneumonia**
__Autism	**__Heart Problems**	**__Recurrent Headaches**
__Bleeding/Transfusions	**__Hepatitis**	**__Rheumatic Fever**
__Blood Disorder	**__Heart Disease**	**__Prolonged Bleeding**
__Bone Disorders	**__Heart Murmur**	**__Radiation/Chemotherapy**
__Cancer/Tumor	**__HIV/Aids**	**__Seizures**
__Cerebral Palsy	**__High Blood Pressure**	**__Sickle Cell Disease/Trait**
__Cleft lip/palate	**__Kidney Problems/Disease**	**__Significant Injuries**
__Congenital Heart Defect	**__Herpes**	**__Speech/Hearing**
__Diabetes	**__Liver Problems**	

Details on any checked item: _____

_____

_____

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

_____

_____

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 Palm Tree Orthodontics all insurance benefits otherwise payable to me for services rendered.**
- **I authorize the use of this signature on all insurance submissions.**
- **I authorize Palm Tree 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 Palm Tree Orthodontics visits or activities of events through video, photo and digital camera, to be used solely for the purposes of Palm Tree 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: _____ /_____ / _____