



Patient's Name \_\_\_\_\_ Title \_\_\_\_\_

Prefers to be called \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

How long at this address \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_ Email \_\_\_\_\_

If Patient is minor, who does patient live with \_\_\_\_\_

If Patient is adult, Employer \_\_\_\_\_ Yrs \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

**RESPONSIBLE PARTY (IF MINOR)**

Name \_\_\_\_\_ Title \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

How long at this address \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Yrs \_\_\_\_\_ Occupation \_\_\_\_\_

**2ND RESPONSIBLE PARTY (IF MINOR)**

Name \_\_\_\_\_ Title \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

How long at this address \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Yrs \_\_\_\_\_ Occupation \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**PRIMARY**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone (if different) \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_ Social Security # or Dental ID# \_\_\_\_\_

Employer \_\_\_\_\_ Ins. Carrier \_\_\_\_\_

Group# \_\_\_\_\_ Carrier Phone # \_\_\_\_\_

**SECONDARY**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different) \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone (if different) \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_ Social Security # or Dental ID# \_\_\_\_\_

Employer \_\_\_\_\_ Ins. Carrier \_\_\_\_\_

Group# \_\_\_\_\_ Carrier Phone # \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of last examination \_\_\_\_\_ General Health \_\_\_\_\_

Medications Taken \_\_\_\_\_

Allergies (medicines/environmental) \_\_\_\_\_

Has patient ever had or been treated for:

- |   |  |  |  |   |   |
|---|--|--|--|---|---|
| <input type="checkbox"/> asthma         | <input type="checkbox"/> chicken pox             | <input type="checkbox"/> drug addiction          | <input type="checkbox"/> HIV+                  | <input type="checkbox"/> measles              | <input type="checkbox"/> strep infection  |
| <input type="checkbox"/> arthritis      | <input type="checkbox"/> freq. colds/sore throat | <input type="checkbox"/> ear infections          | <input type="checkbox"/> influenza             | <input type="checkbox"/> mental health issues | <input type="checkbox"/> tonsillitis      |
| <input type="checkbox"/> AIDS           | <input type="checkbox"/> dermatitis              | <input type="checkbox"/> epilepsy                | <input type="checkbox"/> heart problems/murmur | <input type="checkbox"/> mononucleosis        | <input type="checkbox"/> thyroid problem  |
| <input type="checkbox"/> blood disorder | <input type="checkbox"/> diabetes                | <input type="checkbox"/> freq. headaches         | <input type="checkbox"/> kidney problems       | <input type="checkbox"/> pneumonia            | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> bronchitis     | <input type="checkbox"/> digestion problem       | <input type="checkbox"/> hearing problems        | <input type="checkbox"/> learning disabilities | <input type="checkbox"/> rheumatic fever      | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> cancer         | <input type="checkbox"/> diphtheria              | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> liver problem         | <input type="checkbox"/> sensory issues       | <input type="checkbox"/> vision problems  |

Has the patient ever had surgery (type and when) \_\_\_\_\_

Does patient take antibiotic pre-medication before dental appointments? \_\_\_\_\_

**DENTAL HISTORY**

Dentist \_\_\_\_\_ Date of last examination \_\_\_\_\_

Does patient have:  Abnormal swallowing  Bleeding gums  Poor hygiene habits  Snoring  Mouth BreathingPatient habits:  Nail biting  Night grinding  Thumb/finger sucking  Other \_\_\_\_\_

Does the patient play a musical instrument by mouth? \_\_\_\_\_

IF MINOR: Height: Father \_\_\_\_\_ Mother \_\_\_\_\_ Patient \_\_\_\_\_ Female: Age of onset of menstrual period \_\_\_\_\_

Chief Orthodontic Concern: \_\_\_\_\_ Previous orthodontic experience \_\_\_\_\_

**NOTES:** \_\_\_\_\_  
\_\_\_\_\_**EMERGENCY INFORMATION**

Name of nearest relative: \_\_\_\_\_ Phone # \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

**Patient Acknowledgement and Authorization:**

I hereby acknowledge the above information to be accurate and complete. I give permission for Greeley & Nista Orthodontics, PA to perform an exam and take diagnostic records, including photographs and x-rays for the purpose of determining treatment. I will notify Greeley and Nista Orthodontics, PA of any change in patient's health.

Signature (Parent/Guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

**Insurance Authorization and Assignment of Benefits:**

I authorize release of any information relating to the orthodontic claim. I authorize payment directly to Greeley & Nista Orthodontics, PA of any insurance benefits.

Signature (Parent/Guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_