

ORTHODONTIC PATIENT INFORMATION

Today's Date _____
Patient's Name _____ Date of Birth _____
Name of Patients's Physician _____ Sex: Male Female
Covered by Dental Insurance? Yes No Patient's Cell# _____
Reason for seeking orthodontic evaluation _____

Has anyone in the family had orthodontic treatment? _____

Habits: Thumb or finger sucking? Mouth breathing? Tooth grinding? Click or pain in jaw?
 Other _____

HAS THE PATIENT HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Fever	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems, Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing or Sight Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores - Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Physical Handicap	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient allergic to Penicillin? _____

Please list any other medications the patient is allergic to _____

Please list any medicine the patient is taking _____

Is the patient up to date on their tetanus vaccine? Yes No

Does the patient have any other disease, condition or problems that we should know about?

Who may we thank for referring you? _____

FAMILY HISTORY

Guarantor's Name _____

SS# _____ Date of Birth _____

Street Address _____

City /State/Zip _____ Home Phone # _____

Employer _____ Work Phone # _____

Insured's Name _____ Cell Phone # _____

Name of Dental Insurance Co. _____

Policy / Group #, if different than SS# _____

2nd Guarantor's Name _____

SS# _____ Date of Birth _____

Street Address _____

City / State / Zip _____ Home Phone # _____

Employer _____ Work Phone # _____

2nd Insured's Name _____ Cell Phone # _____

Name of Dental Insurance Co. _____

Policy / Group #, if different than SS# _____

Child resides with: ___Father ___Mother ___Both

Email: _____

We Make Smiles Children's Dentistry & Orthodontics

WRIGHT FAMILY DENTISTRY, PLLC

I hereby authorize Dr. Wright , Dr. Levin, Dr. Hasty and/or Dr. Rosenblum and such assistants as they may designate to treat this patient using procedures including restorative, oral surgery, and patient management techniques that are reasonable, necessary and deemed advisable by the Doctors.

I understand that I am financially responsible for all services rendered. It is office policy to accept insurance assignment for the amount my insurance will pay. I am requested to pay any deductible not met, and my share of fees at time of treatment. The computer files the insurance claim the day after my child's date of service. The office requests PAYMENT IN FULL on the insurance accounts after sixty days have lapsed from the date of filing. It is necessary to follow-up on my insurance claim due to no payment, I realize this is my responsibility, not the doctor's, or this office.

I accept responsibility for payment of the dental services performed. The parents or guardians of the patient are responsible for payment of the account. The office will gladly file your dental insurance; however the parents or guardians are responsible for all fees regardless of insurance coverage. If the account is referred for collection, the parents or guardians will be responsible for their balance plus all costs incurred collecting the account (which include attorney fees of 33 1/3% plus court fees).

I authorize payment directly to Drs. Wright , Levin, Hasty and Rosenblum.

I authorize release of any information relating to this claim.

I permit a copy of this authorization to be used in place of the original.
(This applies to any request from my insurance carrier.)

INTEREST IS COMPUTED ON UNPAID BALANCE AT THE RATE OF 18% ANNUALLY (1-1/2% MONTHLY)

SIGNATURE GUARANTOR

DATE