RAWLINS ORTHODONTICS

# Patient Information

*(Please fill out this form prior to your appointment.)*

Date: _____
Name: _____ Soc. Sec. #_____
Nickname: _____ Sex:_____ Date of Birth:_____ Age:_____
Address:_____
Patient Work Phone: _____ If a minor, give parent's or guardian's name: _____
Home Phone: _____ Cell: _____
Email address: _____ Whom may we thank for referring you? _____
General Dentist: _____ Physician: _____
Reason for Consultation _____
Have you ever been examined by an orthodontist? ☐Yes ☐No If yes, when? _____ Had Braces? ☐Yes ☐No
Siblings' names & ages: _____
Any family members had orthodontics? _____ Where? _____
School: _____ Grade: _____ Interests: _____

# Medical Information

Is patient in good health? ..... ☐Yes ☐No
Does the patient have any history of major illness? ..... ☐Yes ☐No
Has patient ever been under the care of a physician for illness? ..... ☐Yes ☐No
If yes, give reason: _____
Has puberty been reached (menstruation or voice change)? _____

Check any of the following for which the patient has been treated or diagnosed with:

| | | | |
|---|---|---|---|
| ☐ Heart Complications | ☐ Emphysema | ☐ Venereal Disease | ☐ Pneumonia |
| ☐ High Blood Pressure | ☐ Tuberculosis | ☐ A.I.D.S. | ☐ Bone Disorders |
| ☐ Low Blood Pressure | ☐ Asthma | ☐ H.I.V. Positive | ☐ Herpes/Cold Sores |
| ☐ Rheumatic Fever | ☐ Latex Sensitivity | ☐ Blood Transfusion | ☐ Anemia |
| ☐ Arthritis / Rheumatism | ☐ Allergies | ☐ Hemophilia/ Prolonged Bleeding | ☐ Psychiatric/ Psychological Care |
| ☐ Kidney Complications | ☐ Sinus Trouble | ☐ Neurological Disorders | ☐ Periodontal Disease |
| ☐ Ulcers | ☐ Cancer | ☐ Epilepsy or Seizures | ☐ Endocrine Problems |
| ☐ Diabetes | ☐ Hepatitis A (Infectious) | ☐ Fainting/Dizzy Spells | ☐ Liver Involvement |
| ☐ Thyroid Problems | ☐ Hepatitis B (Serum) | ☐ Nervous/Anxious | ☐ Hypoglycemia |

Does patient take any bisphosphonate medications for osteoporosis, such as Fosamax? _____
Does the patient have a tendency to colds? ☐Yes ☐No Sore Throats? ☐Yes ☐No Ear Infections? ☐Yes ☐No
Have tonsils and/or adenoids been removed? ☐Yes ☐No At what age? _____
List any drugs or medications now being taken and give reasons: _____
_____
List any allergies or drug sensitivity: _____

# Dental History

Have you had any injuries to the face, mouth or teeth? ..... ☐Yes ☐No
Habits: Thumb or finger sucking..... ☐Yes ☐No
Mouth Breathing ..... ☐Yes ☐No
Nail/Lip Biting ..... ☐Yes ☐No
Grinding or Clenching of Teeth..... ☐Yes ☐No
Tongue Thrusting..... ☐Yes ☐No
Have you been informed of any missing or extra permanent teeth? ..... ☐Yes ☐No

-Over Please-

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# Financially responsible Party Information

Name: ☐Ms. ☐Mrs. ☐Miss. ☐Mr. ☐Dr. _____

☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Residence: _____

Mailing Address: _____

How long at this address: _____ Home Phone: _____Cell: _____Work Phone: _____

Previous Address (if less than 3 years): _____

Social Security# _____Birthdate: _____ Relationship to Patient _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed : _____

Social Security# _____Birthdate: _____ Work Phone: _____

# Insurance Information

Do you have orthodontic coverage? ☐Yes ☐No Benefit amount: _____ If no, skip this section.

Insured's name: _____ Insured's Soc. Sec. #: _____

Insured's Employer: _____ Group No. _____ Local No. _____

Insurance Company Name & Address: _____

Insurance Company Phone Number: _____

Secondary Insurance? ☐Yes ☐No Benefit amount: _____ If no, skip this section.

Insured's name: _____ Insured's Soc. Sec. #: _____

Insured's Employer: _____ Group No. _____ Local No. _____

Insurance Company Name & Address: _____

Insurance Company Phone Number: _____

# Emergency Information

Name of nearest relative not living with you: _____

Complete Address: _____

Home Phone: _____ Cell: _____ Work Phone: _____

# Authorization and Release

Please Sign and Initial the following:

_____ In accordance with HIPPA regulations, I hereby give my permission for the office of Dr. R. Baker Rawlins to use patient records and information for diagnosis, treatment planning, promotion, education and insurance purposes.

_____ I authorize the dentist to release any information including the diagnosis, and records for treatment rendered to me or my child, if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated.

_____ I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

Updates: (date & initial) _____ _____ _____ _____

CONFIDENTIAL (for record and pretreatment evaluation)