

**PATIENT INFORMATION****DATE:**

Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Male/ Female: Patient's E-mail: \_\_\_\_\_ Patient's Dentist: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Fathers Name (or Self) \_\_\_\_\_

Last

First

Middle

Residence \_\_\_\_\_

Street

City

Zip

Mailing Address \_\_\_\_\_

Street

City

Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_

Mother's Name (or Spouse) \_\_\_\_\_

Last

First

Middle

Mailing Address \_\_\_\_\_

Street

City

Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ ID # \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Orthodontic Benefit Amount \$ \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes complete below:

Insured's Name \_\_\_\_\_ ID# \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Orthodontic Benefit Amount \$ \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

I hereby authorize payments directly to Hidden Valley Orthodontics otherwise payable to me and authorize release any information relating to the dental insurance claim. Signature \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Street

City

Zip

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

# MEDICAL HISTORY For:

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## Please circle Yes or No (If Yes, please fill in details)

Yes No Are you in good health? \_\_\_\_\_  
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 major operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_

Female Patients only: Are you pregnant? Yes \_\_\_ No \_\_\_ Has menstruation started? Yes \_\_\_ No \_\_\_ At what age? \_\_\_\_\_

Male Patients only: Has your voice changed? Yes \_\_\_ No \_\_\_ At what age? \_\_\_\_\_

## Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Congenital Heart Defect	Hepatitis/Liver problems	Pneumonia
Allergies-Metal or Latex	Diabetes	Herpes	Prolonged Bleeding
Anemia	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Arthritis	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Asthma or Hayfever	Heart Problems	Kidney problems	Tuberculosis
Bone Disorders	Heart Murmur	Nervous Disorders	Tumor or Cancer

Please list any medications now being taken. Give reason. \_\_\_\_\_

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

# DENTAL HISTORY

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

What do you want to accomplish with orthodontic treatment? \_\_\_\_\_

Yes No Are you presently in any dental pain? If so, please explain. \_\_\_\_\_  
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 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 Are you aware of any jaw clicking, popping, grinding or clenching? \_\_\_\_\_  
Yes No Do you have "tension" headaches? \_\_\_\_\_  
Yes No If the patient is under age 16, height of parents? Mom \_\_\_\_\_ Dad \_\_\_\_\_  
Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_  
What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

I have read and do understand this paragraph; 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. Fortney, Dr. Moser and the Hidden Valley Orthodontic staff to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print name \_\_\_\_\_

# OTHER INFORMATION

I acknowledge that I have received and read a copy of Hidden Valley Orthodontics Notice of Practice Policies (HIPPA). I also authorize for the release of information and/or x-rays to my referring doctor(s) regarding my/child's orthodontic treatment. \_\_\_\_\_

Initials

In most cases, we may provide "in house" no interest financing of orthodontic treatment. For us to do this for you, we must first run your credit report. This will be done prior to the time that fees arrangements are discussed. If you will be paying for orthodontic treatment in full prior to the start of treatment, we do not need to run this report. I give my permission for Hidden Valley Orthodontics to run my credit report for the purpose of determining financing for orthodontic treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_