

ADULT PATIENT INFORMATION

PLEASE PRINT

Today's Date _____

(circle one): Mr, Mrs, Miss, Ms, Dr, Rev, Prof, Rabbi

Patient's Name _____ S.S.# _____ Sex ____ DOB _____ Age _____

Patient's Full Address _____
City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ E-Mail _____

Occupation _____ Employer's Name _____ Work # _____

Names of Relatives Treated Here _____

Personal Dentist Name _____ Address _____ Tel.# _____

Whom may we thank for referring you to our office? _____ Address & Phone _____

How would you like to receive appointment reminders? Phone US mail email text message (provider: _____)
(check one) required for texting

Information of spouse or other authorized party to make payments on or inquire about your account.

Name _____ Relationship _____ S.S.# _____ DOB _____

Full Address _____
City _____ State _____ Zip _____

Occupation _____ Employer's Name _____ Work # _____

Home Phone (____) _____ Cell Phone _____ E-Mail _____

Insurance Information

We will be happy to assist you in filing your insurance claim. Please bring us a dental claim form for your insurance company with the patient information filled out and signed. However, all payments are the responsibility of the patient, and an account will not be put on hold awaiting insurance benefits.

(We do not accept no fault insurance.)

Please check here if you DO have Orthodontic insurance:

FINANCING OPTION: Our practice offers interest-free financing to assist our patients for orthodontic care. A credit check may be done to confirm your eligibility for financing if you elect to choose this option.

I authorize Southern Tier Credit Center to obtain my consumer credit report from any or all of the three credit bureaus – Equifax, Experian or Trans Union.

Signature

Date

RECORD RELEASE AUTHORIZATION:

I consent to examination and treatment of _____ by the orthodontists and staff of ORTHODONTIC GROUP OF THE FINGER LAKES. I authorize ORTHODONTIC GROUP OF THE FINGER LAKES to release any and all of the named patient's dental records, including but not limited to; records of office visits and treatment rendered, x-rays, x-ray reports and photographs. Such records may be released to another dentist or orthodontist, or any other health care professional, for the purposes of discussing my condition, consulting on my case, or reviewing my dental records. These records may also be released to any governmental agencies, insurance companies, employees of insurance companies, any managed care organizations which contract with my insurer for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to the named patient, or performing quality assurance reviews as required by law. This authorization shall remain in effect for fifteen years from the below said date.

Signature of Patient or Guardian

Print Name

Date

OFFICE USE ONLY:

Model # _____ Office _____ Patient # _____ Information Update ____ / ____ / ____ Initialed _____

Patient Name _____ Record No. _____

Date of Birth ____ / ____ / ____

MEDICAL HISTORY

Physician _____

Address _____

Phone No. _____

1. When was your last physical exam? _____
2. Have there been any changes in your general health with the past year? _____
3. Is a physician for any reason treating you at present? _____
4. What medicine(s) are you taking now? _____
5. Have you ever been hospitalized for any illness, accident or surgery? _____
If yes, when and why? _____
6. Woman: Are you pregnant now? _____

Do you have or have you had any of the following:

	Yes	No	Yes	No
7. Heart Trouble (including heart murmurs, valve, prosthesis/pacemaker)			26. Allergy, hay fever, hives	
8. Rheumatic fever			27. Asthma	
9. High/Low blood pressure			28. Sinus problems	
10. Kidney problems			Are you allergic to or have you had any unusual reactions to the following?	
11. Liver Disease (hepatitis)			Yes	No
12. Jaundice			Unknown	
13. Diabetes			29. Penicillin	
14. Anemia, Sickle cell, Iron			30. Dental local	
15. Prolonged bleeding			31. Barbiturates	
16. Severe infections			32. Codeine or other narcotics	
17. Epilepsy			33. Aspirin	
18. Fainting			34. Sedatives	
19. Convulsions			35. Sulfa	
20. Pneumonia			36. Specify other	
21. Tuberculosis			Do you have any other disease, condition emotional problems you would like to bring to our attention?	
22. Venereal Disease, AIDS, ARC				
23. Latex or vinyl (glove) allergy				
24. Metal Allergies (jewelry, etc.)				
25. Arthritis				

I Hereby consent to the initial examination, including taking of diagnostic radiography's (x-rays), photographs and casts as deemed necessary by Orthodontic Group of the Finger Lakes. I understand that if treatment is not started within 60 days of the initial consultation, I will be billed \$260.00 for diagnostic records taken. If I do begin treatment, the cost of these records will be included in the total treatment cost.

Date _____ Signature (self/guardian) _____

DO NOT WRITE BELOW THIS LINE

FOR DOCTOR'S USE ONLY

Summary of medical history/ medical problems affecting dental treatment:

HX obtained from _____ Reviewed by Dr. _____ Date ____ / ____ / ____

DENTAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:

	YES	NO
Orthodontic (straightening of the teeth) As a child _____, or an adult _____.		
Extractions How long ago _____ Reason for extractions _____		
Periodontal treatment		
Mouthguard or splint (plastic device between your teeth)		
Treatment or surgery to change your bite		

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

Sores, lumps or irritated areas in your mouth		
Food catching or collecting between your teeth		
Clenching or grinding your teeth		
Clicking, popping or grating noise in your jaw when chewing Does it bother you? _____		
Numbness or tingling in your mouth or face		
Would you change anything about your teeth or smile?		

Over the past five years, how often have you been seen for teeth cleaning? _____

The date of your last visit to a dentist _____.

That dentist's name _____

DATE: _____ PATIENT SIGNATURE _____