PRETTYMAN ORTHODONTICS

WELCOME! Please tell us about the patient.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Title: _____

Preferred Name/Nickname: _____

Street Address: _____ Apt/Unit#: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender: _____ Ethnic Origin: _____

Home Phone: _____ School: _____ Grade: _____

Email: _____

Has the patient been seen at any of our other locations? ☐ Yes ☐ No If yes, where: _____

Whom can we thank for referring you to us? _____

Dentist's Name: _____ Last Visited: _____

Other family members treated here: _____

Name(s) and age(s) of siblings: _____

In case of emergency, call: _____ Phone: _____

Mother's Name: _____ Date of Birth: _____

Address: _____

Employer: _____ Social Security Number: _____ - _____ - _____

Work Phone: _____ Cell Phone: _____ Email: _____

Father's Name: _____ Date of Birth: _____

Address: _____

Employer: _____ Social Security Number: _____ - _____ - _____

Work Phone: _____ Cell Phone: _____ Email: _____

MEDICAL HISTORY

Please check box if the patient has or has had:

- ☐ Positive HIV test
- ☐ Joint swelling
- ☐ Bone disorders
- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Prolonged bleeding
- ☐ Faintness/dizziness
- ☐ Tonsils removed
- ☐ Tonsillitis
- ☐ Adenoids removed
- ☐ Brain injury
- ☐ Emotional problems
- ☐ Kidney/liver issues
- ☐ Ear aches
- ☐ Hepatitis

(OVER)

MEDICAL HISTORY (continued)

Does the patient have any medical concerns? _____

Physician's Name: _____

Please list any medications that the patient is currently taking: _____

_____

Are there any problems that may prohibit us from providing the patient with successful treatment? ☐ Yes ☐ No

If yes, explain: _____

Females only: Is the patient pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Please list any habits that we should be aware of (such as thumb sucking, nail biting, lip biting, tongue thrust, grinding, clenching, snoring): _____

Has the patient had any injuries to the face, mouth, or teeth? _____

Please describe in detail the main concerns that brought the patient to our office: _____

_____

_____

INSURANCE INFORMATION

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security Number/ID Number: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

AUTHORIZATIONS

Insurance Authorization:
I authorize my insurance company to pay directly to Dentistry of the Carolinas and their associate dentists my insurance benefits that would otherwise be payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I have received, read, understand, and accept DOC's Insurance and Financial Policy. In addition, by signing below I agree to receive calls from DOC staff at work, home, or by mobile phone to discuss matters related to my dental treatment, insurance, and financial arrangements.

_____
Patient/Legal Guardian Signature

Authorization for Treatment:
I consent to the procedure decided upon to be necessary or advisable in the opinion of the Orthodontist.

_____ _____
Patient/Legal Guardian Signature Date