Atlantic ORTHODONTICS

*In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.*

# *Patient Information*

*Today's Date*_____

Patient Name _____ Nickname _____

☐ Male ☐ Female SS # _____ Date of Birth ____/____/____ Age _____

Home Address_____
*Street* *City* *State* *Zip*

Primary Phone_____ ☐ Home ☐ Cell Email_____

Have we treated another member of your family? ☐Yes ☐No _____
*Name*

Have you visited an orthodontist before? ☐Yes ☐No
What are your main concerns that you would like to accomplish? _____

_____

How did you hear about us? ☐Ad ☐Social Media (Facebook/ Instagram) ☐Internet
☐Family/Friend: Name_____ ☐Doctor_____
☐Other_____

# *Medical History*

Physician _____ Telephone_____

**Allergies or Reactions to ANY of the following:**

☐ Local Anesthetics ☐ Aspirin/Ibuprofen ☐ Codeine ☐ Latex ☐Ibuprofen ☐ Metals
☐ Penicillin ☐ Amoxicillin ☐ Sulfa Drugs ☐ **None** ☐ Other_____

List any prescription, over the counter, or herbal medications being used:
_____

**Treated for in the past or present:**

☐ Abnormal Bleeding ☐ ADD/ADHD/ADHA ☐ Anemia ☐ Artificial Bones/Joints/Valves
☐ Asthma ☐ Autism ☐ Cancer ☐Congenital Heart Defect ☐ Convulsion/Epilepsy
☐ Diabetes ☐ Handicaps/Disabilities ☐ Hearing/Sight Impairment ☐ Heart Murmur
☐ Heart Attack/Stroke ☐ Hemophilia ☐ Hepatitis ☐ HIV/+AIDS ☐ TB
☐ Kidney/Liver Disease ☐ Lupus ☐ Osteoporosis ☐ Radiation Treatment ☐ **None**
☐ Other _____

# *Dental History*

General Dentist _____ Phone Number _____

Date of last cleaning _____

| | | |
|---|---|---|
| Are you presently in any dental pain? | ☐ Yes | ☐ No |
| Have your tonsils or adenoids been removed? | ☐ Yes | ☐ No |
| Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? | ☐ Yes | ☐ No |
| Are you aware of your jaw clicking or popping? | ☐ Yes | ☐ No |
| Do you have 'tension' headaches? | ☐ Yes | ☐ No |
| Are there any missing or extra permanent teeth? | ☐ Yes | ☐ No |
| Are there any speech problems? | ☐ Yes | ☐ No |
| Have you ever had injury to (*select all that apply*): | Teeth | |

Any of the following habits (present or past):

| | | |
|---|---|---|
| ☐ Clenching/ Grinding Teeth | ☐ Mouth Breathing | ☐ Thumb/ Finger Sucking |
| ☐ Lip Sucking/ Biting | ☐Nail Biting | ☐Chewing/ Eating Problem |

For school age patients:

School _____ Grade_____

Please list any sports of extracurricular activities, and hobbies:

_____

Any Siblings (Names & Ages)

_____

# *Responsible Party Information*

**Primary Financial Party:**

Relationship to Patient: Parent

Name _____ Date of Birth: ____/____/____

SS # _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address (if different than patient's)

_____

*Street* *City* *State* *Zip*

Phone #_____☐ Home ☐ Cell Alternate #_____☐ Home ☐ Cell

**Secondary Financial Party:**

Relationship to Patient: Parent

Name _____ Date of Birth: ____/____/____

SS # _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address (if different than patient's)

_____

*Street* *City* *State* *Zip*

Phone #_____☐ Home ☐ Cell Alternate #_____☐ Home ☐ Cell

# *Emergency Contact*

Name:_____ Phone # _____

Relationship to Patient _____

Address_____

*Street* *City,* *State,* *Zip*

Person(s) OK to release appointment, X-Ray, records, or medically related information concerning patient.

_____ Relation(s) _____

_____ Relation(s) _____

# *Dental Insurance Information*

Policy Holder's Name _____ Relationship to Patient_____

Policy Holder's SS#_____ Policy Holder's Birth Date _____

Employer_____ Work Phone #_____

Insurance Company _____ Phone Number_____

Member ID #_____ Group # _____

♦ I give my permission for Atlantic Orthodontics, Dr Brianne C. DeSantis, D.M.D., M.S. to keep my signature on file for use in insurance authorizations, claim submissions, and releasing patient information to my dental insurance company. I authorize and request my insurance company to pay the office directly any benefits for treatment performed on the patient.

♦ I hereby authorize the release of any information pertaining to my child's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

♦ I understand that insurance companies pay the office periodically over the course of treatment, based on the agreement in the insured's policy. I understand that even if the patient's treatment has finished earlier than originally estimated, canceling my insurance policy may leave me with a balance to be paid to the office.

♦ I acknowledge that I have read and have been offered a copy of the Notice of Privacy Practices effective 1/2009. I consent to the disclosure of health information as described for treatment, payment, or health care operations. I also understand that I have the right to withhold consent.

♦ I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be kept in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status.

♦ I understand that any court ordered documents regarding foster care, adoption, or other transfer of guardianship must be presented at the first appointment following any of the above actions taking place.

♦ I consent to Atlantic Orthodontics using my email and/or cell phone number to send verbal and written appointment reminders.

_____

Signature of Responsible Party Date

Notes:_____

_____

_____

_____

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