HIDDEN SMILES ORTHODONTICS

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Practice Limited To Orthodontics and Dentofacial Orthopedics
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Patient Information:

Name:_____
First **Middle** **Last**
Date Of Birth: _____/_____/_____ Phone Number:_____
Address:_____
No. **Street** **City** **State** **Zip Code**
Names/Ages of siblings if a minor:_____
_____

Responsible Party Information:

Name:_____ Married___ Divorced___ Single___
First **Middle** **Last**
Custodial Parent: Mother____Father____Both____ E-mail Address:_____
Home Phone: (____)_____Cell Phone: (____)_____Work Phone:(____)_____
Employer:_____Occupation:_____
Social Security #: ____-___-_____ Date of Birth:____/____/____ Work Phone (____)_____
Spouse's Name:_____
First **Middle** **Last**
Employer:_____Occupation_____No. Years Employed:_____
Social Security #: ____-___-_____ Date of Birth:____/____/____ Work Phone (____)_____

Dental Insurance Information:

Primary
Policy Holder:_____
SS# of Policy Holder: ____-____-_____
Policy Holder Date of Birth: ____/____/____
Insurance Company:_____
Insurance Group/Policy#_____
Address_____

Secondary
Policy Holder:_____
SS# of Policy Holder: ____-____-_____
Policy Holder Date of Birth: ____/____/_____
Insurance Company:_____
Insurance Group/Policy#_____
Address_____

I hereby authorize release of any information to other health care providers, insurance companies, and business associates, including personal health information as well as administrative date which is not strictly dental or medical in nature. I additionally authorize payment directly to **Hidden Smiles Orthodontics** of the insurance benefits otherwise payable to me. I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I certify that the above information is complete and true to the best of my knowledge.

Signature_____Date:_____

Patient's Dentist: _____ Phone#: (___) _____ Last Visit: _____
What is patient's primary concern: _____
_____
_____
Patient's Physician: _____ Phone#: (____) _____ Last Visit: _____
Is patient presently being treated by a physician? Yes No Why?: _____
_____
Has the patient's tonsils and adenoids been removed? Yes No
Has the patient ever had an unusual reaction to any drug? Yes No
Does patient have a speech problem, if so are they receiving therapy? Yes No
Has the patient any of the following?

- □ Heart Murmur
- □ Rheumatic Fever
- □ Mitral Valve Prolapse
- □ Pre Medication Required
- □ Anemia
- □ Bleeding Problems
- □ Gum Problems
- □ Tuberculosis
- □ Diabetes
- □ Epilepsy
- □ Convulsions/Seizures
- □ Immune Deficiency
- □ Smoke Cigarettes/Cigars
- □ Asthma
- □ Breathing Problems
- □ Frequent Colds
- □ Sinus Problems
- □ Cold Sores
- □ ADD/ADHD
- □ Ulcers
- □ Thyroid/Hormonal Imbalance
- □ Lip Biting
- □ Nail Biting
- □ Tongue Thrusting
- □ Presently Suck Thumb/Finger
- □ Arthritis
- □ Problems Opening/Closing
- □ Chewing Problems
- □ Jaw Popping
- □ Grinding/Clenching
- □ Concussion
- □ Injury to Teeth/Jaws
- □ Severe Headaches
- □ Facial Pain
- □ Any TMJ History
- □ Nervous Disorder
- □ Hearing Problem
- □ Latex Allergy
- □ Metal Allergy
- □ Seasonal Allergy
- □ Other Allergy:

List: _____
_____
_____
_____

- □ Major Surgery

_____
_____
_____

Has Patient ever had orthodontic treatment or worn a retainer? Yes No
Does anyone else in the family have a similar orthodontic problem? Yes No If so, who: _____

Names of Daily Medications? _____
Is there any other information about the patient's health we should know? _____
_____
_____

Whom may we thank for the referring you to our office?
Please circle all that apply:

My Dentist Staff Member at My Dentist Office Selected Doctor from Insurance Provider List

Website Invisalign® Website Yellow Page Ad Newspaper Ad in: _____

My Friend/Relative Referred Me (list name(s)): _____
_____

Other (please specify): _____
_____
_____

Signature: _____ Date: ___/___/____