*Thank you for choosing Oliver Orthodontics! Please complete this form in ink, **FRONT and BACK**. Ask if you need assistance.*

Patient Information

(Please Print)

Name_____Age_____Gender_____
First Middle Last

Birthdate_____SS#_____Home Phone #_____Cell #_____

Address_____City_____State_____Zip_____

Employer_____Occupation_____Work Phone_____

If patient is a student, name of school/college_____

Email Address_____

Are you: ( )Minor ( )Single ( )Married ( )Divorced ( )Separated ( )Widowed

Person to contact in case of an emergency_____Phone #_____

Name of any family members/friends we have treated_____

Who may we thank for referring patient to us? _____

I, _____, do consent to Oliver Orthodontics taking any necessary diagnostic records, consisting of X-rays, photographs, and dental impression, for _____ in order to diagnose and formulate an orthodontic treatment plan. I authorize the use of any and all photographic pictures taken by Oliver Orthodontics in clinical presentations, new patient consultations, advertising/marketing and social media purposes.

_____ _____
Signature Date

Responsible Billing Party (please complete if patient is a minor)

Name_____ DOB_____

Address_____City_____St_____Zip_____

Home #_____ Work #_____ Cell #_____

Occupation_____ Employer_____ SS#_____

Email_____

Relationship to Patient_____

Spouse

Name _____ DOB _____

Address_____ City _____ St_____Zip_____

Home #_____ Work #_____ Cell #_____

Occupation_____ Employer_____ SS#_____

Email_____

Relationship to Patient_____

Dental Insurance Information

NOTE: Insurance information must be completely filled out in order to file for your benefits.

Primary Insurance Co._____ Address_____

Group#_____Contract#_____Phone#_____

Employer_____Employment Date_____

Subscriber Name_____Birthdate_____SS#_____

Relationship to Patient_____Lifetime Orthodontic Maximum $_____

Secondary Insurance Co._____ Address_____

Group#_____Contract#_____Phone#_____

Employer_____Employment Date_____

Subscriber Name_____Birthdate_____SS#_____

Relationship to Patient_____Lifetime Orthodontic Maximum $_____

Dental History

Name of Dentist_____Date of Last Cleaning_____
In your own words, why have you come to the orthodonist?
_____
Was this problem brought to your attention by your dentist? _____
Did he/she recommend that you come here for treatment? _____

Please check any of the following conditions that apply to patient:

( )Bad Breath	( )Headaches	( )Periodontal Care	( )Grinding Teeth
( )Bleeding gums	( )Jaw Pain	( )Mouth Breather	( )Food Between Teeth
( )Sores/growth in mouth	( ) Neck Pain	( )Earaches	( )Sensitivity to Cold / Hot
( )Clicking/Popping Jaws	( )Loose Teeth	( )Cleft Palate	( ) Sensitivity on Biting

Medical History

Name of Physician_____Date of last visit_____
Please list all medications patient is currently taking:_____
Does patient require premedication?_____
Allergies:_____

(Women) Is the patient pregnant? ( )Yes ( )No

Does patient have a history of any of the following?

( )AIDS	( )Circulatory Problems	( )Kidney Disease	( )Shortness of Breath
( )Anemia	( )Cough, Persistent	( )Liver Disease	( )Skin Rash
( )Arthritis, Rheumatism	( )Diabetes	( )Mitral Valve Prolapse	( )Stroke
( )Artificial Heart Valves	( )Epilepsy/Fainting	( )Nervous Problems	( )Swelling of Feet
( )Artificial Joints	( )Heart Problems	( )Pacemaker	( )Thyroid Problems
( )Asthma	( )Hepatitis	( )Psychiatric Care	( )Tobacco Habit
( )Blood Disease	( )High Blood Pressure	( )Radiation Treatment	( )Rheumatic Fever
( )Cancer/Chemo		( )Respiratory Disease	( )Venereal Disease

Describe heart problems_____

Other medical issues not listed above_____

_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the health of the patient. It is my responsibility to inform this office of any changes in the patient's medical status. I authorize the orthodontist to release any information including the diagnosis and the records of any treatment or examination rendered to patient during the period of such orthodontic care to third party payers and/or health practitioners. I understand that dental insurance may pay less than the actual amount owed for services. I agree to be responsible for payments of all services rendered on my or patient's behalf.

_____ _____

Signature of Patient (or Guardian if patient is a minor) Date