Cabezon ORTHODONTISTS

The benefit of a happy, healthy smile is immeasurable! Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely and to the best of your knowledge

ABOUT YOU

Name: _____
I prefer to be called: _____ Male/Female
Birthdate: _____Age:_____
SS#:_____--_____--_____

Home Address: _____

_____
City State Zip

____ Single ____Married _____Divorced ____ Widowed

Home#_____ Cell#_____
Work#_____ ext._____

Email address_____
Employer:_____
Occupation_____ How long_____
Whom may we thank for referring
you?_____

YOUR SPOUSE

Name: _____
Employer: _____
Phone#: _____
SS#_____--_____--_____
Birthdate:_____

IN CASE OF EMERGENCY

Please indicate a neighbor or relative not living with you.

Name: _____**Relation:**_____
Work #_____ **Home#** _____

Address: _____

_____
City State Zip

INSURANCE

Primary Insurance

Do you have Dental coverage? _____
Insurance Co. Name: _____
Insurance Co. Phone#: ( ) _____
Group #: _____
Policyholder: _____
Date of Birth:_____
Social Security # _____
Employer: _____
Second Insurance Co. Name: _____
Second Policyholder: _____
Date of Birth: _____
Social Security#: _____

Insurance

Insurance is filed as a courtesy to you.
It is the responsibility of the policy holder to know the policy limits and maximums. Insurance is not a guarantee of payment if insurance fails to pay its estimated portion I understand that I will be responsible for the remaining balance.
_____initials

Assignment and Release

I, the undersigned, certify that I or my dependent have insurance coverage and assign directly to Cabezon Orthodontists. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I hereby authorize Cabezon Orthodontists to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party signature

Relationship_____

Date:_____

Please complete this section when the responsible party for the account is <u>not</u> listed on this form.
Person responsible for account_____
Home#_____ _Work#_____
Relationship: _____
Billing Address: _____

_____
City state Zip

Medical History

Do you have a physician? Yes no

Physician's Name: _____

Address: _____

Phone: _____Date of last visit _____

Your current health is excellent good poor

Are you currently under the care of a physician? Yes No

If yes please explain: _____

Do you smoke or use tobacco of any form? Yes No

Have you had any metal Pins, Rods, Implants or Joint replacements? Yes No

Are you taking ANY medications? Yes No

Please list each one:

_____

_____

Have you had any of the following medical problems or diseases?

__ Alcohol/Drug abuse
__ Anemia
__ Anxiety
__ Artificial bones/joints/valves
__ Asthma
__Blood/bleeding Disorder
__Bone disorder
__ Cancer /Chemotherapy
__ Colitis
__ Diabetes
__ Difficulty Breathing
__Emphysema
__ Epilepsy/seizures
__Endocrine problems
__ Fainting Spells
__ Frequent Headaches
__ Glaucoma
__ Heart problems
__ Heart Murmur
__ Hepatitis
__ Herpes/Fever Blisters
__ High Blood Pressure
__Immune disorder
__Kidney Problems
__Liver Disease
__Low blood Pressure
__ Osteoporosis/osteopenia
__ Pneumonia
__ Psychiatric Problems
__ Radiation Treatment
__ Rheumatic/Scarlet Fever
__ Shingles
__ Sickle cell disease/trait
__ Sinus Problems
__ Sleep Apnea
__ Stroke
__ Thyroid Problems
__ Tuberculosis
__ Ulcers

Please list any serious medical conditions that you have ever had:

_____

Have your_____ tonsils or _____adenoids been removed?

If yes, at what age? _____

Please circle if you are allergic to any of the following?

Aspirin	Erythromycin	Penicillin
Codeine	Metals	Tetracycline
Dental Anesthetics	Latex	Other

Please list any other drugs/materials you are allergic to:

_____

_____

For women: Are you currently taking any birth control pills? Y/N

Are you pregnant Y/N Week#_____

Are you currently nursing? Yes No

Have you ever taken Phen-Phen/ Redux? Yes No

If yes when? _____

Dental History

Do you have regular Dentist? Yes No

Dentist Name: _____

Specialist?: _____

When did you last receive dental care: _____

Routine or Emergency (circle one)

Your Current dental health is excellent good poor

How frequently do you brush your teeth? _____

Use dental floss? _____

Do you take antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you have any jaw, joint or facial pain? Yes No

Have your teeth or either of your jaws been injured Yes No

If yes, how old were you? _____ If yes, what was the cause of the accident? _____ Which teeth and/or jaw were involved? _____

Have you ever had an unfavorable dental experience? Yes No

Do you like your smile? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Have you been informed of any missing or extra permanent teeth?

_____

Do you have, or have you ever had any of the following habits?

__Lip sucking __Thumb or Finger sucking

__Lip biting __Constant mouth breathing

__Nail biting __Tongue thrusting

__Grinding teeth __Other_____

Do you have a speech problem?

_____

Describe your orthodontic problem as you it?

_____

Does anyone in your family have a similar dental or facial condition?

_____

Has anyone else in your family received orthodontic care?

_____

Has an orthodontist been consulted previously?

_____

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 held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature_____

Date_____

****It is the responsibility of the policy holder to know the policy limits and maximums. ****