Patient Information Form

Today's Date _____

PATIENT DETAILS

Preferred Office: ☐ East Spartanburg ☐ West Spartanburg ☐ Duncan ☐ Gaffney ☐ Union

Patient's Legal Name_____ Preferred Name _____

Patient's Date of Birth _____ Gender _____ Email _____

Patient's Address _____
Street City Zip

Cell Phone _____ Alternate Phone _____

Dentist _____ Primary Physician _____

Whom may we thank for your referral? _____ Patient's School_____

Emergency Contact Name/Number _____
Name Relationship to Patient Phone #

PRIMARY RESPONSIBLE PARTY (Please complete this section even if you are also the patient)

Legal Name_____ Relationship to Patient _____

Date of Birth _____SS# _____ Cell Phone _____ Alt Phone _____

Email Address_____ Appointment reminders by? Text / Email / Both / None

Employer _____Occupation_____

Dental Insurance Co Name _____ Of which State? _____

Subscriber ID #_____ Subscriber Group Number _____

Dental Ins Co Phone Number for Providers _____ Orthodontic Lifetime Max $_____

Dental Ins Company Mailing Address _____

SECONDARY RESPONSIBLE PARTY

Legal Name_____ Relationship to Patient _____

Date of Birth _____SS# _____ Cell Phone _____ Alt Phone _____

Email Address_____ Appointment reminders by? Text / Email / Both / None

Employer _____Occupation_____

Dental Insurance Co Name _____ Of which State? _____

Subscriber ID #_____ Subscriber Group Number _____

Dental Ins Co Phone Number for Providers _____ Orthodontic Lifetime Max $_____

Dental Ins Company Mailing Address _____

I understand that I am responsible for payment of services rendered, along with any portion my insurance does not cover. I hereby authorize this practice to release all information necessary to secure the payment of benefits, and if applicable, assign directly to this practice all insurance benefits otherwise payable to me. I further authorize the use of my signature on all of my insurance submissions, whether manual or electronic.

_____ _____
Signature of Adult Patient age 18 and over, or Parent, or Guardian Date

PATIENT INFORMATION FORM PAGE 2 MEDICAL HISTORY/DETAILS

☐Yes ☐No **1. Has the patient been treated for any medical conditions in the past year? IF YES, Please List:**
_____

☐Yes ☐No **2. Has the patient ever been hospitalized or had surgery for any condition? IF YES, Please List:**
_____

☐Yes ☐No **3. Is the patient taking medications of any kind? IF YES, please list medications and the reason for them:**
_____

☐Yes ☐No **4. Does the patient have any allergies? IF YES, Please List: _____**

☐Yes ☐No **5. Does the patient have or have they ever had any of the following? Please check all that apply.**
☐ADD/ADHD ☐Autism/Down Syndrome ☐Emotional Disorder ☐Mental Health Disorder ☐Learning Disability
☐TMJ ☐Ear Infections ☐Seizures/Epilepsy ☐Cancer ☐Diabetes ☐Heart Condition ☐HIV/Aids
☐Hepatitis/Liver Disease ☐Arthritis ☐Cancer ☐Diabetes ☐Thyroid Disease ☐Ear Infections ☐Cleft Palate
☐Hearing Loss/Deafness ☐Loss of Eyesight/Blindness ☐Fainting/Dizziness ☐Kidney Disease ☐Organ Transplant

☐Yes ☐No **6. Are there any conditions/diseases not listed above that the patient has or has had? If Yes, Please List:**
_____

DENTAL HISTORY/DETAILS

☐Yes ☐No **1. Has the patient had an orthodontic consultation previously?**

☐Yes ☐No **2. Has the patient had prior orthodontic treatment? Orthodontist's Name: _____**

☐Yes ☐No **3. Has the patient had any prior injury to teeth (baby or perm)? Please Describe:**
_____

☐Yes ☐No **4. Has the patient had any cysts or tumors of the jaws or gums? Please Describe:**
_____

☐Yes ☐No **5. Has the patient been informed of any missing or extra permanent teeth?**

☐Yes ☐No **6. Does the patient suck thumb, fingers, or have similar habits? Please describe: _____**

☐Yes ☐No **7. Have you had a dental cleaning in past 12 months? Date of cleaning: _____**

☐Yes ☐No **8. What is the reason for the patient's visit today? _____**

☐Yes ☐No **9. Does the patient require an antibiotic prophylaxis prior to having dental work done?**

FOR FEMALES ONLY:

☐Yes ☐No **Are you pregnant? Expected delivery date? _____** ☐Yes ☐No **Are you on birth control?**

I understand that the information I have provided is accurate to the best of my knowledge, and that it will be held in the strictest confidence based on current HIPAA compliance and the privacy policy published in each of our office locations. I understand it is my responsibility to inform this orthodontic office of any changes to the patient's medical or dental status. I authorize Nth Degree Orthodontics to perform the necessary orthodontic services to comprise an orthodontic treatment plan.

_____ _____

Signature of Adult Patient age 18 and over, or Parent, or Guardian Date