Shrewsbury Orthodontics

Adult Patient Information

Patient's Full Name_____ **Age** _____ **D.O.B** _____ **Male** _____ **Female** _____

Telephone#_____ **Cell#**_____ **E-mail address:**_____

Address _____ **Town** _____ **State**_____ **Zip** _____

Name of any other family members who have been here before _____

Dentist _____ **Town** _____ **last cleaning date** _____

Name of Physician _____ **Town** _____ **Telephone**_____

Are you allergic to any medications ? _____**List** _____
Do you have any latex allergies ? _____
Do you have any other allergies ?_____**List** _____
Are you taking any medications ? _____

Do you participate in any sports or other activities? Please list - _____

Do you have any of the following: ( )ADD/ADHD ( ) Asthma ( ) Anemia ( ) Cancer ( )Convulsions ( )Diabetes ( )Epilepsy ( )Hearing ( )Kidney or Liver Disease ( )TB ( )Emotional problems ( ) Heart ( )Mono ( )Tumors ( ) HIV/AIDS
( ) Rheumatic Fever ( ) Convulsions ( ) Excessive Bleeding ( ) Speech OTHER _____

Do you need pre-med for normal dental cleanings? _____ **Pharmacy Name & #** _____
Have you had any other orthodontic treatment done in the past ?_____**When** _____
Do you experience pain or discomfort in the jaw joint? _____
Do you have any missing or extra permanent teeth that you are aware of _____

Financial Information

Person responsible for account _____

Name _____ **SSN#**_____ **D.O.B.**_____

Address _____

Home # if different _____ cell phone _____

Employer's Name & number _____ **Occupation**_____

Spouse Name _____ **SSN#**_____ **D.O.B.**_____

Address if different _____

Home # if different _____ cell phone _____

Employer's Name & number _____**Occupation**_____

Marital Status ( ) Single ( ) Married ( ) Divorced/Separated ( ) Widowed

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
Employee name _____ SSN#_____D.O.B. _____

Address_____ State_____ Zip _____ Phone#_____
Employer (name, address, phone) _____

Primary Insurance - Is patient covered w/ortho under your plan ?_____ **Max-**_____

Secondary Insurance - Is patient covered w/ortho under your plan ?_____ **Max.**_____

Subscriber Name_____

Subscriber Name_____

Insurance co._____ **Group #**_____
Address _____
Phone # _____

Insurance co. _____ **Group#**_____
Address _____
Phone # _____

IMPORTANT (please complete this side)

*****Who can we thank for referring you ? _____

PAYMENT IS DUE AT TIME OF APPOINTMENT , UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate and to the best of my knowledge.

I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I acknowledge that the office charges for no-show appointments ($75.00 to $100)

Signature _____ Date _____

SHREWSBURY ORTHODONTICS

Acknowledgement of receipt of notice of privacy practices

I, _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES .

Name (please print) _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because : (Circle one)

- Individual refused to sign
- Communications barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____