Shrewsbury Orthodontics

Patient Information

Patient's Full Name_____ **Nickname**_____ **Age** _____**D.O.B-**_____

Male _____ **Female**_____ **Telephone#**_____ **Parents cell#**_____

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

Email address of parent _____

Name of any other siblings who have been here before _____

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

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

Is patient allergic to any medications ? _____**List** _____
Does patient have any latex allergies ? _____
Does child have any other allergies ?_____**List** _____
Is child taking any medications ? _____

What sports or other activities does he/she participate in ? Please list - _____

Has child had 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_____

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

Financial Information

Person responsible for account _____

Father's Name _____ **SSN#**_____ **D.O.B.**_____

Address if different than child _____ Home # if different _____ cell phone _____

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

Mother's Name _____ **SSN#**_____ **D.O.B.**_____

Address if different than child _____
Home # if different _____ cell phone _____

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

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

Dental Insurance Information

If insured is *DIFFERENT* than above parents - please list - (ex. step parent) Relationship to Patient _____
Employee name _____ SSN#_____ D.O.B. _____
Address _____ State_____ Zip _____

Employer Name, address phone #_____

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

Subscriber Name_____

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

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

Subscriber Name_____

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 _____