

WELCOME

1

About Your Child

Today's Date: ___/___/___ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ Boy Girl

Child's Birthdate: ___/___/___ Age: _____

School: _____ Grade: _____

Child's Home Phone #:(_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

2

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? Yes No

Secondary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3

Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) _____ RELATION TO CHILD _____

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? _____ Age(s): _____

Mother's Name: _____
 STEP MOTHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) (_____) _____
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
 STEP FATHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) (_____) _____
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

4

Account Information

Person ultimately responsible for account

Name: _____ RELATION TO CHILD _____

Billing Address: _____
CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____) (_____) _____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

REFERRAL SOURCE

Whom may we thank for referring you?	<input type="checkbox"/> Dentist <input type="checkbox"/> Patient	<input type="checkbox"/> Internet Ad <input type="checkbox"/> Internet search	<input type="checkbox"/> Insurance <input type="checkbox"/> Radio	<input type="checkbox"/> Yellow Pages Book <input type="checkbox"/> Yellow Pages Online	<input type="checkbox"/> Other (specify)
Name of Referrer:					

DENTAL/MEDICAL HISTORY

What is your main reason for visiting the orthodontist today?

General Dentist: _____ Phone: _____

Address: _____ Last Visit: _____

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Do you like your smile? Yes No Do your gums bleed? Yes No How many times a week do you floss? _____

How many times a day do you brush? _____

Physician Name: _____ Physician Phone: _____ Last Visit: _____

Your current physical health is: Good Fair Poor Are you taking any prescription drugs? Yes No Drug and Dose: _____

Are you currently under the care of a doctor? Yes No Explain: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

<input type="checkbox"/> Y <input type="checkbox"/> N	Prosthesis	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Convulsions/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hi/Lo blood pressure		
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Drug/Alcohol Abuse		
<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Fever blister	<input type="checkbox"/> Y <input type="checkbox"/> N	Artificial Valves	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood Transfusion		
<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart surgery/Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia/Radiation Treatment		
<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcers/Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Any Stays in Hospital	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma		
<input type="checkbox"/> Y <input type="checkbox"/> N	HIV+/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney/Liver Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty Breathing?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever		
<input type="checkbox"/> Y <input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Artificial bones/joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Other:		
<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N	Severe/Freq headaches				
Are you allergic to any of the following?		<input type="checkbox"/> Y <input type="checkbox"/> N	Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N	Dental Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N	Tetracycline	<input type="checkbox"/> Y <input type="checkbox"/> N	Other:
		<input type="checkbox"/> Y <input type="checkbox"/> N	Antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> N	Latex	<input type="checkbox"/> Y <input type="checkbox"/> N	Penicillin	Women Only: Are you Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N	

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are dedicated to protecting your personal medical information and following all provisions required by law. I hereby acknowledge that I have reviewed a copy of the Privacy Notice and the information used or disclosed per this Privacy Authorization may be subject to re-disclosure by the recipient(s), and this, no longer protected by the privacy rules. _____ (Please Initial)

CONSENT TO X-RAYS

It is necessary to take diagnostic x-rays in order to determine an appropriate treatment plan and patient diagnosis. Your signature below authorizes Pavlik Orthodontics to take these necessary x-rays.

I understand the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Legal Guardian _____ Date _____

S. Jason Pavlik, DMD _____ Date _____