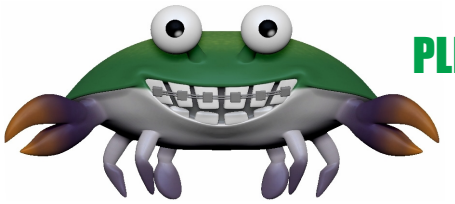
Welcome to our practice!



PLEASE FILL OUT ALL THREE PAGES

Today's Date:_____

Name:_____Preferred Name:_____
LAST, FIRST MI

Birthday:____/_____/_____ Gender: M F Age:_____

Marital Status: Single Married Widowed Divorced Separated

Home Address: _____

Cell#: (_____)_____ Work# (_____)_____ Email:_____

Where and when are the best times to reach you?:_____

Employer: _____ Occupation:_____

General Dentist _____ Date of Last Dental Visit: _____

Who may we thank for referring you? _____

Who is responsible for account:

Guarantor Name:_____Birthdate:_____

Address: (If different than above) _____

Home # _____ Cell # _____ Email _____

Employer: _____Occupation: _____Work # _____

In the event of an emergency, please contact:

Name:_____ Relation:_____ Phone:_____

Insurance Information:

Orthodontic Coverage Yes No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Secondary Orthodontic Coverage Yes No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Medical History

Are you currently taking medications/over-the-counter drugs (including vitamins/supplements)? Yes No

If so, please list here:_____

Are you allergic to any medications or dental products? Yes No

If so, please list here: _____

Are you under the care of a physician? Yes No

Physician's Name: _____ Phone _____

(Women) Is there a possibility that you are currently pregnant? Yes No
(Women) Are you taking birth control pills? Yes No

Please list any serious medical condition(s) that you have ever had:

_____

_____

Have you experienced any of the following:

Yes	No	Abnormal bleeding	Yes	No	Convulsions
Yes	No	Heart murmur	Yes	No	Prosthetics
Yes	No	ADD/ADHD	Yes	No	Diabetes
Yes	No	Heart Surgery/Pacemaker	Yes	No	Rheumatic Fever
Yes	No	AIDS/HIV+	Yes	No	Epilepsy
Yes	No	Hemophilia	Yes	No	Scarlet Fever
Yes	No	Any hospital stay/operations	Yes	No	Frequent headaches
Yes	No	Hepatitis	Yes	No	Seizures/Fainting
Yes	No	Arthritis	Yes	No	Handicaps/Disabilities
Yes	No	Herpes/Fever blisters	Yes	No	Shingles
Yes	No	Artificial bones/joints/valve	Yes	No	Hay fever
Yes	No	High/Low blood pressure	Yes	No	Sickle cell disease/traits
Yes	No	Kidney problems	Yes	No	Hearing impairment
Yes	No	Cancer	Yes	No	Tuberculosis (TB)
Yes	No	Liver problems	Yes	No	Heart attack/Stroke
Yes	No	Congenital heart defect	Yes	No	Venereal disease
Yes	No	Mitral valve prolapse	Yes	No	Allergies to Latex

Other (please specify): _____

Do you have allergies to any of the following:

Yes	No	Local anesthetics	Yes	No	Vinyl
Yes	No	Aspirin	Yes	No	Metals
Yes	No	Ibuprofen	Yes	No	Codeine or other narcotics
Yes	No	Sulfa Drugs	Yes	No	Acrylic
Yes	No	Food (specify):	Yes	No	Animals

Other (specify): _____

Dental History

Yes	No	Have you ever been evaluated or had orthodontic treatment before?
Yes	No	Have you seen a general dentist in the last 6 months?
Yes	No	Have there been any injuries to the face, mouth, teeth or chin?
Yes	No	Do you require antibiotics before dental treatment?
Yes	No	Do you smoke or use tobacco in any form?
Yes	No	Have you ever had difficulties associated with previous dental work?
Yes	No	Do you have any pain/tenderness in his/her jaw joint (TMJ/TMD)?
Yes	No	Do you brush and floss your teeth daily?
Yes	No	Are you aware of any "gum" problems?
Yes	No	Do you have any of the following habits? (If so, please circle)
		Clenching/Grinding teeth or nail biting or thumb/finger sucking
		Lip sucking/biting or tongue thrust or mouth breather

Why have you come to see Dr. Koterwas today? i.e. crowding, overbite, etc...

Please Initial the Following & Sign

_____ I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my status **including insurance assignment**. I authorize the dental staff to perform the necessary dental/orthodontic services I may need.

_____ I authorize Dr. Koterwas Orthodontics to communicate with my general dentist and/or other healthcare providers involved in my treatment. This includes x-rays, medical record information or any relevant documentation deemed necessary to render treatment and coordinate care for the patient.

_____ I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____ I hereby authorize Dr. Koterwas Orthodontics, DDS, LLC and/or Koterwas Orthodontics of Prince Frederick to release all information necessary to secure the payment of benefits. I also assign, directly to the doctor, all insurance benefits otherwise payable to me.

Patient Signature Date