WELCOME to our practice. Please help us provide you with the most complete service by sharing the following information and completing a health history.

PATIENT'S INFORMATION

Name: ____ Preferred Name: ______________
Last First Middle Initial

Date of Birth: __ __ / __ __ / __ __ __ __ Age: ______ Gender: ______ SSN/SIN: __ __ __ - __ __ - __ __ __ __

Phone:
Home: (__ __ __) __ __ __ - __ __ __ __ Work: (__ __ __) __ __ __ - __ __ __ __ Cell: (__ __ __) __ __ __ - __ __ __ __

Address: ____
Street City State ZIP Code

School/Employer: ____

SPOUSE/CLOSEST RELATIVE

Name of Spouse/Closest Relative: ____________________/_________ Contact Number: (__ __ __) __ __ __ - __ __ __ __
Relationship

Address: ____
Street City State ZIP Code

INFORMATION ABOUT PATIENT'S DENTIST

Name: ______________________________ Date Last Seen: ____________________

Reason for Last Visit: ______________________ Phone: (__ __ __) __ __ __ - __ __ __ __

Address: ____
Street City State ZIP Code

INFORMATION ABOUT PATIENT'S PHYSICIAN

Name: ______________________________ Date Last Seen: ____________________

Reason for Last Visit: ______________________ Phone: (__ __ __) __ __ __ - __ __ __ __

Address: ____
Street City State ZIP Code

Who suggested pursuing orthodontic treatment? ____

Why did you select our office? ____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

Name: ____/__________ Contact Number: (__ __ __) __ __ __ - __ __ __ __
Relationship

Address: ____
Street City State ZIP Code

INSURANCE INFORMATION

Coverage for Dental Treatment? _____ Coverage for Orthodontic Treatment? _____

Name of Primary Policy Holder: ___________________________________ SSN/SIN: __ __ __ - __ __ - __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __ Employer: ____

Dental Insurance Company: ____ Group Number: ______________________

Medical Insurance Company: ____

Name of Secondary Policy Holder: ___________________________________ SSN/SIN: __ __ __ - __ __ - __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __ Employer: ____

Dental Insurance Company: ____ Group Number: ______________________

Medical Insurance Company: ____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have (or my dependent has) insurance coverage with ___________________________________ and assign directly to Dunlow Orthodontics, P.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dunlow Orthodontics, P.C., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ________________________ ________________________
Responsible Party's Signature Relationship Date

DENTAL HISTORY

Please circle any of the following dental conditions that the patient has currently or had in the past.

Extra Teeth	Teeth Removed	Injured/Broken Teeth	Sensitive Teeth	Broken Jaw
Tumors/Cysts of Jaw	Root Canal	Dry Mouth	Bleeding Gums	Gum Disease
Crooked Teeth	Sores in Mouth	Sucking Thumb/Finger	Biting Fingernails	Grinding Teeth
Clicking or Popping Jaw	Loose Teeth	Biting of Cheeks	Space Between Teeth	Food Collection Between Teeth
Over- or Under-developed Jaw	Mouth Breathing	Snoring/Difficulty Breathing	Problems with Wisdom Teeth	Pain/Sensitivity When Biting

MEDICAL HISTORY

Please circle any of the following medical conditions that the patient has currently or had in the past.

Abnormal Bleeding	HIV/AIDS	Artificial Joints/Valves	Drug/Alcohol Abuse	Pneumonia
Blood Transfusion	Mitral Valve Prolapse	Heart Murmur	Fever Blisters/Herpes	Immune Condition
Tuberculosis (TB)	Frequent Headaches	Hepatitis/Liver Disease	Arthritis	Vision Problems
Diabetes	Ulcers/Colitis	Psychiatric Problems	Endocrine Problems	Hearing Problems
Emphysema	Anemia	Shingles	Kidney Problems	Speech Difficulties
Glaucoma	Cancer	Venereal Disease	Thyroid Problems	Eating Disorder
Heart Attack/Stroke	Difficulty Breathing	Epilepsy/Seizures	Sinus Problems	Osteoporosis
High/Low Blood Pressure	Tonsil/Adenoid Problems	Congenital Heart Defect	Heart Surgery/Pacemaker	Rheumatic/Scarlet Fever

Has the patient ever been hospitalized for any reason? ……	Yes	No
Is the patient allergic to any medications or substances? ……	Yes	No
Is the patient currently taking any medications, including over-the-counter drugs and supplements? ……	Yes	No
FEMALES ONLY: Are you pregnant? ……	Yes	No
FEMALES ONLY: Has menstruation begun? ……	Yes	No
Has puberty begun? ……	Yes	No
Does the patient smoke or use smokeless tobacco? ……	Yes	No
Does the patient have any medical conditions not listed above? ……	Yes	No

I have read and understand the questions above and certify that the information provided is accurate to the best of my knowledge. I authorize Dr. Dunlow and the staff at Dunlow Orthodontics, P.C., to perform any dental services that may be required for appropriate diagnosis and treatment of the patient listed above.

______________________________ ______________ ______________

Signature of Patient/Legal Guardian **Relationship** **Date**

Comments

______________________________ ______________

Neil E. Dunlow, DDS, MS **Date**