COLUMBIA ORTHODONTICS, PC

Adult New Patient Information

Today's Date: ____/ _____ / _____

M or F

Patient Name: First_____ Last_____ DOB: _____/_____/_____ Age:_____

Home Address: _____City _____Zip_____ How long at this address? :_____

Home#: ( ) _____-_____ Work #: ( ) _____-_____ Cell# ( ) _____-_____ SS# _____ - _____ - _____

Employer: _____ How many months/years?_____ Occupation:_____

Email address: _____

General Dentist: Dr. _____ What are your orthodontic concerns/goals?:_____

_____

Spouse's Name: First_____ ____Last_____DOB:_____/_____/_____

SS# _____ - _____ - _____Work#: ( ) _____-_____Cell #: ( ) _____-_____

Employer:_____ How many months/years?_____ Occupation:_____

How did you hear about our office?

Doctor/Dentist	Name:	Friend/Family	Name:
Yellow Pages/Phone Book	Name:	One of our Team Members	Name:
Internet	Search Engine:	Drive by/Walk in	Location:

*__Emergency Contact *Not* Residing with You* Name:_____ _____ Contact #: ( ) _____-_____

Relationship:_____Email address:_____ _____

Do you have insurance? If yes, please refer to our Insurance Information form.

Health History

Has the patient ever been evaluated or had orthodontic treatment before?	Y es	No
Have there been any injuries to the face, mouth, teeth or chin?	Y es	No
Have adenoids or tonsils been removed?	Y es	No
Has the patient been informed of any missing or extra permanent teeth?	Y es	No
Does the patient brush their teeth daily?	Y es	No
Floss daily?	Y es	No
Has the patient ever had any pain or tenderness in their jaw joint? TMJ?	Y es	No
Has puberty begun?	Y es	No
Has menstruation begun?	Y es	No
Is the patient currently under the care of a physician?	Y es	No
Is the patient currently taking any medication?	Y es	No

Medication taken:_____

Physician's name:_____ Phone#: ( ) _____ Date of Last Visit:_____

Has the patient ever had any of the following medical problems?

Abnormal Bleeding	Y es	No	Diabetes	Y es	No
ADD/ADHD	Y es	No	Handicaps/Disabilities	Y es	No
Allergies to any Drugs	Y es	No	Heart Murmur	Y es	No
Allergic to Latex/Metals	Y es	No	Hemophilia	Y es	No
Allergic to Plastic	Y es	No	Hepatitis	Y es	No
Any Hospital Stays	Y es	No	HIV+/AIDS	Y es	No
Any Operations	Y es	No	Kidney Problems	Y es	No
Artificial Bones/Joints/Valves	Y es	No	Liver Problems	Y es	No
Asthma	Y es	No	Lupus	Y es	No
Cancer	Y es	No	Rheumatic/Scarlet Fever	Y es	No
Congenital Heart Defect	Y es	No	Sickle Cell Disease/Traits	Y es	No
Convulsions/Epilepsy	Y es	No	Tuberculosis	Y es	No

PLEASE LIST ALL ALLERGIES AND / OR and any medical problems that you would like to discuss:

_____

_____

Does the patient have any of the following habits?

Clenching/Grinding teeth	Y es	No	Speech Problems	Y es	No
Lip Sucking/Biting	Y es	No	Thumb/Finger Sucking	Y es	No
Mouth Breather	Y es	No	Tongue Thrust	Y es	No
Nail Biting	Y es	No			

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. If this office accepts insurance, I assign directly to Dr. Croft all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

This office reserves the right to verify to credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____ _____

Signature Date

COLUMBIA ORTHODONTICS, PC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of the offices Notice of Privacy Practices.

Print Name

_____

Signature

_____

Date

For office use only

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining this acknowledgment
- □ An emergency situation prevented us from obtaining the acknowledgment
- □ Other (please specify)

_____

_____

Insurance Information Form

Please fill out this form completely so that we can accurately verify and bill your insurance.

Patient legal name:_____ DOB:_____

Name of Insured/ Relationship to patient	Date of Birth	Social Security Or ID#	Employer	Insurance Company	Group #	Benefits Phone #
Primary: Relationship:						
Secondary: Relationship:						
Additional: Relationship:						

In addition to the above information, we need the **current** home address of ***all*** insurance parties.

Please make sure this information is filled out on the **NEW PATIENT INFORMATION** sheet.