



**NEW PATIENT INFORMATION**

Today's Date: \_\_\_/\_\_\_/\_\_\_ Nick Name: \_\_\_\_\_

Patient Name: First \_\_\_\_\_ Last \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ M or F

Primary Residence: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Contact #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Brothers/Sisters names & ages: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

**General Dentist:** \_\_\_\_\_ What are your orthodontic concerns/goals?: \_\_\_\_\_

**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:

**Custodial Parent:** First \_\_\_\_\_ Last \_\_\_\_\_ Relationship to Child \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_ How long at this address?: \_\_\_\_\_ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ How many months/years? \_\_\_\_\_ Occupation: \_\_\_\_\_

**Spouse's:** First \_\_\_\_\_ Last \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Email address \_\_\_\_\_

Employer: \_\_\_\_\_ How many months/years? \_\_\_\_\_ Occupation: \_\_\_\_\_

**Non-Custodial Parent:** First \_\_\_\_\_ Last \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ Home #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_ How long at this address?: \_\_\_\_\_ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ How many months/years? \_\_\_\_\_ Occupation: \_\_\_\_\_

**Spouse:** First \_\_\_\_\_ Last \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ How many months/years \_\_\_\_\_ Occupation \_\_\_\_\_

**\*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
<b>Allergic to Latex/Metals</b>	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** discuss any medical problems that pertain to the patient: \_\_\_\_\_

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			

**\*Emergency Contact Not Residing with You\* Name:** \_\_\_\_\_ Contact #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_ Email address: \_\_\_\_\_

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.

\_\_\_\_\_  
Signature Parent or guardian (if patient is minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Dr.

\_\_\_\_\_  
Date

**COLUMBIA ORTHODONTICS, PC**

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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\*You may refuse to sign this acknowledgment\*

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

Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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For office use only

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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)
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This form is educational only, does not constitute legal advice and covers only federal, not state law. (August 14, 2002)

# 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.