

Drs. Toothman & Barra, P.A.

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you.
We look forward to working with you.

PATIENT INFORMATION

Name _____ Gender: Female or Male
Address _____
City _____ State _____ Zip _____
Phone _____ Social Security # _____
Birthday _____ Single/Married/Widowed/Separated/Divorced
Patient Employed by _____ Occupation _____
Business Address _____
Business Phone _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home _____ Work _____

RESPONSIBLE PARTY INFORMATION

Name _____ Birthday _____
Address _____
Previous Address if less than 1 Yr. _____
Home Phone _____ Social Security # _____ Driver's License #/State _____
Employer _____ Work Phone _____
Occupation _____ Years Employed _____

DENTAL HISTORY

General Dentist _____
Why are you interested in orthodontic treatment? _____
Date of last dental check-up? _____
Have you ever had orthodontic treatment or been evaluated for orthodontic treatment? Yes _____ No _____
Do you have any jaw related discomfort? _____
Have you ever experienced a mouth or chin injury? _____
Do you have speech problems? _____
Does you have any habits/problems affecting the mouth or teeth? (Nail-biting or Thumb or Finger Sucking etc.) _____
Do you usually breathe through your mouth while awake? _____ Asleep? _____
Have you ever experienced an adverse reaction in conjunction with a medical or dental procedure? _____
Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician Name _____ Phone _____
Date of last visit _____ Has you had any serious illnesses or operations? If yes, describe _____

Are you currently under physician care? Yes _____ No _____ Describe _____

Have your tonsils/adenoids been removed? Yes _____ No _____

Women: Are you pregnant? Yes _____ No _____ Nursing? Yes _____ No _____

Check if you have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Allergy to Drugs/Medicines | <input type="checkbox"/> Describe _____ |
| <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergy to Materials | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> (latex, metal, chemicals) _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mitral Valve problems |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Nervous problems |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Pacemaker/ Heart Surgery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Rheumatic/ Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia-Abnormal Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis |

List medications you are taking: _____

Does you have any conditions that require premedication prior to any dental procedures? _____

AUTHORIZATION

- I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my child's medical status, I will inform the orthodontist.
- I authorize all insurance benefits otherwise payable to me for services rendered, to be paid to Drs. Toothman & Barra, P.A. (if applicable).
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I understand that, with in house financing, credit bureau reports may be obtained.
- I give my approval and consent for my name and/or photograph to be used in scientific and/or promotional work produced by Drs. Toothman & Barra, P.A. and their staff.

Signature _____ Date _____

INSURANCE

To be filled out by patient:

PRIMARY INSURANCE

Subscriber Name _____
Relation _____ Birthday _____ Social Security # _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Subscriber Employed By _____ Occupation _____
Business Address _____
Business Phone _____
Insurance Company _____ Phone _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional orthodontic insurance? _____
Subscriber Name _____ Relation to Patient _____ Birthday _____
Address _____
City _____ State _____ Zip _____
Social Security # _____
Subscriber Employed By _____ Business Phone _____
Insurance Company _____ Phone _____
Contact # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please bring your insurance card so that we may obtain a copy.