

PATIENT INFORMATION

Today's Date _____

Patient's Name _____ Birth Date _____ Age _____

Nickname _____ Patient's SS# _____ Sex Male / Female

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Cell Number _____ Text Messaging Yes / No

Other family members treated here _____ How did you hear about us? _____

RESPONSIBLE PARTY / LEGAL GUARDIAN INFORMATION NUMBER 1

Name _____ Birth Date _____

Social Security # _____ Drivers License # _____ Relationship to Patient _____

Marital Status __Single __Married __Divorced __Widowed E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Home Number _____ Cell Number _____ Work Number _____

Employer _____ Occupation _____

Spouses Name _____ Relationship to Patient _____

RESPONSIBLE PARTY / LEGAL GUARDIAN INFORMATION NUMBER 2

Name _____ Birth Date _____

Social Security # _____ Drivers License # _____ Relationship to Patient _____

Marital Status __Single __Married __Divorced __Widowed E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Home Number _____ Cell Number _____ Work Number _____

Employer _____ Occupation _____

Spouses Name _____ Relationship to Patient _____

HEALTH HISTORY

Dentist Name _____ Date of Last Cleaning _____

Is the patient currently under a Physician's care? Yes or No If yes, please list Physician Name and Phone Number _____

Please list any medication currently taking _____

Please list any drug allergies _____

Has the patient ever taken any medication for osteoporosis? Yes or No If yes, please explain _____

Please circle any of the following which may apply to the patient:

Pregnant	Tuberculosis	Cancer	Latex Allergy	Diabetes
Hepatitis A, B, or C	Heart Murmur	Congenital Heart Defect	Rheumatic Fever	HIV Positive/ AIDS
Hearing Impairment	Asthma	Kidney/Liver Problems	Convulsions/Epilepsy	Abnormal Bleeding
Jaw Clicking	Finger Sucking	Scarlet Fever	Handicaps/Disabilities	Allergies to Any Drugs
			Hemophilia	Smoking

Please explain any of the above: _____

Please list any special needs: _____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes.

Signature (Guardian if a Minor) _____ Date _____

INSURANCE INFORMATION FORM

Today's Date _____

PRIMARY DENTAL INSURANCE

Policy Holder's Name _____ Birth Date ___/___/___ SS# _____

Policy Holder's Employer _____

Insurance Company Name _____ Effective Date _____

Policy # _____ Group # _____

Insurance Company Address _____

Insurance Company Phone _____

Orthodontic Coverage: Yes / No

I hereby authorize payment of the group insurance benefits directly to Central Texas Orthodontics:

Signature (Insured Person / Policy Holder) _____ Date _____

Office Use Only: Max _____% up to \$ _____ Insurance Assigned / Not Assigned Paid: Auto / Monthly / Quarterly

SECONDARY DENTAL INSURANCE

Policy Holder's Name _____ Birth Date ___/___/___ SS# _____

Policy Holder's Employer _____ Effective Date _____

Insurance Company Name _____

Policy # _____ Group # _____

Insurance Company Address _____

Insurance Company Phone _____

Orthodontic Coverage: Yes / No

I hereby authorize payment of the group insurance benefits directly to Central Texas Orthodontics:

Signature (Insured Person / Policy Holder) _____ Date _____

Office Use Only: Max _____% up to \$ _____ Insurance Assigned / Not Assigned Paid: Auto / Monthly / Quarterly

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review and keep a copy of Central Texas Orthodontics' Notice of Privacy Practices.

Please Print Name _____

Patient Name _____

Patient Date of Birth _____

Signature _____

Date _____

YEARLY UPDATE

Date _____ Initial _____ Date _____ Initial _____ Date _____ Initial _____