WELCOME TO King ORTHODONTICS

Please complete, sign and date both sides of this form.

Patient's Name: _____
first middle last

Address: _____
street city state zip

Phone: _____
home work cell

Birthdate: ____/____/____ Social Security: _____

Patient's Nickname (if any): _____ Dental Insurance: _____

Father's Name: _____
first middle last

Address: _____
street city state zip

Phone: _____
home work cell

Email: _____

Birthdate: ____/____/____ Social Security: _____

Father's Employer: _____ Dental Insurance: _____

Mother's Name: _____
first middle last

Address: _____
street city state zip

Phone: _____
home work cell

Email: _____

Birthdate: ____/____/____ Social Security: _____

Mother's Employer: _____ Dental Insurance: _____

Whom may we thank for referring you? *(please circle one)*

Family Dentist Friend Newspaper Movie Ad Web-Site

_____ _____
Signature (parent or guardian if patient is a minor) Date

(over)

HEALTH HISTORY

Patient's Name: _____
first middle last

Family Dentist: _____ Clinic: _____
name

Last check-up or cleaning within 6 months? YES NO

Family Physician: _____ Clinic: _____
name

Last physical within 1 year? YES NO

Allergic Reactions (CIRCLE)

Latex Aspirin Ibuprofen Other: _____

Frequently Experienced (CIRCLE)

Headaches Fainting Teeth Grinding Thumb/Finger Habit

Vomiting Gagging TMJ Problems Other: _____

Diagnosed or Treated (CIRCLE)

Heart Murmur Asthma Seizures Hearing Impaired Rheumatic Fever

Head Trauma Diabetes Anemia Hepatitis Joint Replacement/Implants

Teeth Trauma Arthritis HIV/AIDS Blood Pressure Other: _____

If female, Are you Pregnant? _____ If yes, due date _____

Does the patient require antibiotic pre-medication for dental treatment? YES NO

Medications (PLEASE LIST)

1. _____ Reason _____

2. _____ Reason _____

3. _____ Reason _____

INSURANCE ASSIGNMENT AND RELEASE – I, the undersigned assign directly to KING ORTHODONTICS all insurance benefits, otherwise payable to me for services rendered.
I also hereby authorize KING ORTHODONTICS to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

FINANCIAL RESPONSIBILITY – I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware of the financial policies regarding patient services, payment and insurance assignment if applicable.

In accordance with the federal government HIPAA rules, please sign below to acknowledge you have received our Notice of Privacy Practices; it will in no way affect the care you receive at King Orthodontics.

_____ _____
Signature (parent or guardian if patient is a minor) Date

(over)