PATIENT INFORMATION FORM

Nease & Higginbotham Orthodontics

Today's Date: _____

PERSONAL DETAILS

Patient's Name _____ **Preferred Name** _____

Patient's Address _____ _____ **Zip** _____
street city state

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Date of Birth _____ **SS#** _____ **Gender**___ **School** _____ **Grade**_____

Dentist Name _____ **Primary Physician's Name** _____

To whom may we thank for your referral _____

RESPONSIBLE PARTY DETAILS

Please refer to our practice brochure, Notice of Privacy Policies & Practices, Communications with Family Please note below all family and/or responsible party members that are allowed or authorized to receive information pertaining to your or your child's orthodontic treatment. It is your responsibility to notify our office immediately if any of this information should change.

Name _____ **Relationship to Patient** _____

Address _____ _____ **Zip** _____
street city state

Home Phone _____ **Cell Phone** _____ **Email Address** _____

Date of Birth _____ **SS#** _____ **DL#** _____

Employer _____ **Occupation** _____ **Work Phone** _____

Address _____ _____ **Zip** _____
street city state

Primary authorized contact(s) _____ **Phone** _____

Primary authorized contact(s) _____ **Phone** _____

ORTHODONTIC INSURANCE - PRIMARY

Insured's Name _____ **Relationship to Patient** _____

Insured's Birthdate _____ **SS#** _____ **Insured's Employer**_____

Insurance Co. Name _____

Insurance Co. Address _____ _____ **Zip** _____
street city state

Insurance Co. Phone _____ **Group Plan or Policy #** _____

Lifetime Benefit _____ **ID #** _____

ORTHODONTIC INSURANCE - SECONDARY

Insured's Name _____ **Relationship to Patient** _____

Insured's Birthdate _____ **SS#** _____ **Insured's Employer**_____

Insurance Co. Name _____

Insurance Co. Address _____ _____ **Zip** _____
street city state

Insurance Co. Phone _____ **Group Plan or Policy #** _____

Lifetime Benefit _____ **ID #** _____

AUTHORIZATION

This office reserves the right to verify the 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 credit reporting agency. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the orthodontist to release all information necessary to secure the payment of benefits. And if applicable, assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent or Guardian **Date**

PATIENT INFORMATION FORM

Nease & Higginbotham Orthodontics

PERSONAL DETAILS

Y N 1. Does the patient have a health problem?
If YES please list _____

Y N 2. Is there a history of serious illness, accident or operation?
If YES please list _____

Y N 3. Is the patient under a doctor's care for any problem at this time?
If YES please list _____

Y N 4. Is the patient taking any medication?
If YES please list _____

Y N 5. Does the patient have any allergies or drug sensitivities?
If YES please list _____

DENTAL HISTORY

Y N 1. Has the patient had an orthodontic consultation previously?

Y N 2. Has the patient had any previous orthodontic treatment?

Y N 3. Has the patient had any injury to the teeth? (this includes both baby & permanent teeth)
If YES please list what and when _____

Y N 4. Has the patient had any injury to the face, jaws or chin?

Y N 5. Has the patient had any cysts or tumors of the jaws or gums ?

Y N 6. Have you been informed of any missing or extra permanent teeth?

Y N 7. Does the patient suck fingers, thumb, or have a similar habit?
If YES please list _____

Y N 8. Date of last dental examination _____

Y N 9. Reason for seeking orthodontic treatment _____
_____

Y N Do you require an appointment reminder? _____

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have provided is accurate to the best of my knowledge, and that it will be held in the strictest confidence and that it is my responsibility to inform this orthodontic office of any changes in my child's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services my child may need.

_____
Signature of Parent or Guardian Date

MEDICAL CHECKLIST

Does the patient have or ever had any of the following medical conditions?

- ☐ Allergies or Asthma
- ☐ Arthritis
- ☐ Breathing Difficulties
- ☐ Bleeding disorders
- ☐ Bone disorders
- ☐ Cancer or tumor(s)
- ☐ Cleft palate
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy or convulsions
- ☐ Fainting or dizziness
- ☐ Hearing problems
- ☐ Heart diseases or murmur
- ☐ Hepatitis/Liver Disease
- ☐ HIV or AIDS
- ☐ Latex Allergies
- ☐ Kidney problems
- ☐ Learning disabilities
- ☐ Rheumatic fever
- ☐ Rheumatoid Arthritis
- ☐ Speech problems
- ☐ TMJ
- ☐ Tuberculosis

Spartanburg Location
212 East Blackstock Road
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Visit us at:
www.drnease.com
Member American Association of Orthodontists

Union Location
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T: (864) 427-0161 F: (864) 427-0169