Keaton Orthodontics

Patient Information

Patient Name_____SSN_____Sex_____Height_____Weight_____

Patient Address_____City_____State_____Zipcode_____

Home Phone _____Cell Phone _____Emergency Contact Number_____

E-mail Address _____Date of Birth____-____-____School_____

General Information

Who is accompanying the child today? _____ Do you have legal custody of this child? _____

Parents marital status _____If divorced, are you the custodial parent? _____

May treatment and financial information be released to the non-custodial parent? _____

Other children in the household (Names & DOB)_____

Have any other family members had orthodontic treatment? _____ If yes, where? _____

Who may we thank for referring you to our office? _____

Guardian / Financial Information

Guardian/Father's Name_____SSN_____DOB_____

Employer _____Work Number_____

Employer's address_____

Dental Insurance Company _____Subscriber ID #_____Group #_____

Guardian/Mother's Name_____SSN_____DOB_____

Employer _____Work Number_____

Employer's address_____

Dental Insurance Company _____Subscriber ID #_____Group#_____

Medical and Dental History

Patient's Dentist _____Date of Last Visit_____

Patient's Physician _____Date of Last Visit_____

Reason for seeking orthodontic treatment_____

Please rate the patient's health _____Excellent _____Good _____Fair _____Poor

Please answer Yes or No to the following questions in the space provided

Has the patient been under a physician's care in the past five months? _____
Has the patient been hospitalized or had any serious illness? _____
Has the patient had a reaction to any local or general anesthesia? _____
Has the patient had any change in health in the last five years? _____
Has the patient ever had a blood transfusion? _____
Has the patient experienced excessive bleeding with dental or surgical treatment? _____
Has the patient ever taken bisphosphonates(ie: Boniva Fosamax Osteo meds)? _____If yes, when? _____
Is the patient allergic to any medication or substance (including **latex allergies** or sensitivity)? _____
If yes, name the medication or substance_____
Name of any medication taken previously_____currently_____

Please check if the patient previously had or currently has any of the following:

_____Abnormal Bleeding
_____AIDS/ARC
_____Allergies
_____Anemia
_____Ankle Swelling
_____Arthritis
_____Asthma
_____Autism
_____Auto Accident Injury
_____Behavioral Problems
_____Birth Defects
_____Bleeding Gums
_____Bone Diseases
_____Brain Illness
_____Breathing Problems
_____Bruise Easily
_____Cancer
_____Chemotherapy
_____Chest Pain
_____Chronic Pain
_____Convulsions
_____Diabetes
_____Difficulty Brushing
_____Difficulty Opening Mouth
_____Dizziness
_____Emotional Problems
_____Endocrine Disturbance
_____Epilepsy
_____Excessive Thirst
_____Excessive Weight Loss
_____Facial Pain
_____Fainting Spells
_____Frequent Sore Throat
_____Frequent Urination
_____Growth Disturbance
_____Hearing Problems
_____Heart Disease
_____Heart Murmur
_____Hemodialysis
_____Hemphilia
_____Herpes
_____High Blood Pressure
_____HIV
_____Injured During Sports
_____Intravenous Injections
_____Jaundice
_____Kidney Disease
_____Liver Disease
_____Low Blood Pressure
_____Lung Disease
_____Menstrual Problems
_____Mental Problems
_____Mouth Sores
_____Mouth Breathing
_____Nervous Condition
_____Pacemaker
_____Persistent Cough
_____Persistent Diarrhea
_____Persistent Fever
_____Persistent Tiredness
_____Pregnancy
_____Prosthetic Heart Valve
_____Prosthetic Joint
_____Radiation Therapy
_____Rheumatic Fever
_____Rickets
_____Scarlet Fever
_____Severe Headaches
_____Shortness of Breath
_____Skin Rash of Sores
_____Stomach Problems
_____Stroke
_____Swollen Glands
_____Teeth Knocked Out
_____Thumb Sucking
_____Thyroid Disease
_____TMJ Problems
_____Tobacco Use – any form
_____Tuberculosis
_____Ulcers
_____Venereal Disease
_____Vision Problems
_____Vitamin Deficiency

Authorization / Notice of Privacy Practices Consent

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand the orthodontist will use this information to help determine appropriate and healthful orthodontic treatment. If there is any change in the patient's medical status, I will inform the orthodontist.
I acknowledge Keaton Orthodontics has offered me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature of Responsible Party_____Date_____

Insurance Authorization

I have read and understand the payment policy given to me concerning insurance. I agree to be responsible for all charges for dental services and materials not paid by dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I agree that regardless of my insurance status I am ultimately responsible for the balance due on my account for any professional service rendered. I herby authorize payment of the dental benefits otherwise payable to me directly to Keaton Orthodontics PSC.

Signature of Responsible Party_____Date_____