COLUMBIA ORTHODONTICS, PC

New Patient Information

Today's Date:____/____/____ Nick Name: _____

Patient Name: First _____Last _____DOB:_____/_____/_____ Age: _____ M or F

Primary Residence: _____City/State _____Zip _____

Preferred Contact #: ( ) _____-_____Brothers/Sisters names & ages:_____

School:_____Grade:_____Hobbies/Sports:_____

General Dentist:_____ What are your orthodontic concerns/goals?:_____

How did you hear about our office?

Doctor/Dentist	Name:	Friend/Family	Name:
Yellow Pages/Phone Book	Name:	One of our Team Members	Name:
Internet	Search Engine:	Drive by/Walk in	Location:

Custodial Parent: First_____Last_____Relationship to Child _____

DOB: _____/_____/_____ SS# _____-_____-_____ Home #: ( ) _____-_____Work#: ( ) _____-_____

Home Address:_____City:_____State:_____Zip:_____

Cell #: ( ) _____-_____How long at this address?:_____ Email address: _____

Employer:_____ How many months/years?_____ Occupation:_____

Spouse's: First_____Last_____ Relationship to Child:_____

DOB: _____/_____/_____ SS# _____-_____-_____ Work #: ( ) _____-_____Cell #: ( ) _____-_____

Work #: ( ) _____-_____ __Cell #: ( ) _____-_____ Email address _____

Employer:_____ How many months/years?_____ Occupation:_____

Non-Custodial Parent: First _____Last_____ Relationship to Child:_____

DOB:_____/____/_____ SS# _____-_____-_____ Home #: ( ) _____-_____Work #: ( ) _____-_____

Home Address:_____City:_____State:_____Zip:_____

Cell #: ( ) _____-_____ How long at this address?:_____ Email address: _____

Employer:_____ _ How many months/years?_____ Occupation:_____

Spouse:First_____Last_____Relationship to Child:_____

DOB:_____/____/_____ SS# _____-_____-_____ Work #: ( ) _____-_____ Cell#: ( ) _____-_____

Employer: _____How many months/years _____ Occupation _____

DO YOU HAVE INSURANCE? IF YES, PLEASE REFER TO OUR INSURANCE INFORMATION FORM

Health History

Has the patient ever been evaluated or had orthodontic treatment before?	Y es	No
Have there been any injuries to the face, mouth, teeth or chin?	Y es	No
Have adenoids or tonsils been removed?	Y es	No
Has the patient been informed of any missing or extra permanent teeth?	Y es	No
Does the patient brush their teeth daily?	Y es	No
Floss daily?	Y es	No
Has the patient ever had any pain or tenderness in their jaw joint? TMJ?	Y es	No
Has puberty begun?	Y es	No
Has menstruation begun?	Y es	No
Is the patient currently under the care of a physician?	Y es	No
Is the patient currently taking any medication?	Y es	No

Medication taken:_____

Physician's name:_____ Phone#: ( ) _____ Date of Last Visit:_____

Has the patient ever had any of the following medical problems?

Abnormal Bleeding	Y es	No	Diabetes	Y es	No
ADD/ADHD	Y es	No	Handicaps/Disabilities	Y es	No
Allergies to any Drugs	Y es	No	Heart Murmur	Y es	No
Allergic to Latex/Metals	Y es	No	Hemophilia	Y es	No
Allergic to Plastic	Y es	No	Hepatitis	Y es	No
Any Hospital Stays	Y es	No	HIV+/AIDS	Y es	No
Any Operations	Y es	No	Kidney Problems	Y es	No
Artificial Bones/Joints/Valves	Y es	No	Liver Problems	Y es	No
Asthma	Y es	No	Lupus	Y es	No
Cancer	Y es	No	Rheumatic/Scarlet Fever	Y es	No
Congenital Heart Defect	Y es	No	Sickle Cell Disease/Traits	Y es	No
Convulsions/Epilepsy	Y es	No	Tuberculosis	Y es	No

PLEASE LIST ALL ALLERGIES AND/OR discuss any medical problems that pertain to the patient:_____

_____

Does the patient have any of the following habits?

Clenching/Grinding teeth	Y es	No	Speech Problems	Y es	No
Lip Sucking/Biting	Y es	No	Thumb/Finger Sucking	Y es	No
Mouth Breather	Y es	No	Tongue Thrust	Y es	No
Nail Biting	Y es	No			

***Emergency Contact *Not* Residing with You* Name:_____** Contact #: ( ) _____-_____

Relationship:_____Email address:_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. If this office accepts insurance, I assign directly to Dr. Croft all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature Parent or guardian (if patient is minor) Date

_____ _____

Signature of Dr. Date

COLUMBIA ORTHODONTICS, PC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have received a copy of the offices Notice of Privacy Practices.

Print Name

_____

Signature

_____

Date

For office use only

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining this acknowledgment
- □ An emergency situation prevented us from obtaining the acknowledgment
- □ Other (please specify)

_____

_____

Insurance Information Form

Please fill out this form completely so that we can accurately verify and bill your insurance.

Patient legal name:_____ DOB:_____

Name of Insured/ Relationship to patient	Date of Birth	Social Security Or ID#	Employer	Insurance Company	Group #	Benefits Phone #
Primary: Relationship:						
Secondary: Relationship:						
Additional: Relationship:						

In addition to the above information, we need the **current** home address of ***all*** insurance parties.

Please make sure this information is filled out on the **NEW PATIENT INFORMATION** sheet.