

Patient Information

Patient Name: _____		Nickname: _____	
Date of Birth: _____	Age: _____	Sex: _____	
Telephone: (____) _____			
Address: _____			
City: _____		State: _____	Zip Code: _____
Dentist: _____			
Hobbies: _____			
Employer: _____		Occupation: _____	# Years Employed _____
Work Telephone: (____) _____			
Email: _____			
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>			
Spouses Name: _____			
Employer: _____		Occupation: _____	# Years Employed _____
Work Telephone: (____) _____			
Responsible Party Information			
Name: _____			
SS# _____	Relationship to Patient: _____		
Address: _____			
City: _____		State: _____	Zip Code: _____
Name, phone #, and address of nearest relative not living with you: _____			
Email: _____			
Whom may we thank for referring you to our office? _____			

Medical Information

Physician's Name: _____			
Have you ever been under the care of a physician for serious illness? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please explain: _____			
Have tonsils and adenoids been removed? What age? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>			
Are you pregnant? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>			
List any allergies or medications now being taken:			

Glaucoma <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	
Diabetes <input type="checkbox"/>	Asthma <input type="checkbox"/>	Low Blood Pressure <input type="checkbox"/>	
Pneumonia <input type="checkbox"/>	Kidney Problems <input type="checkbox"/>	Circulatory Problems <input type="checkbox"/>	
Heart Trouble <input type="checkbox"/>	Endocrine Problems <input type="checkbox"/>	Radiation Treatment <input type="checkbox"/>	
Rheumatic Fever <input type="checkbox"/>	Prolonged Bleeding <input type="checkbox"/>	Arthritis <input type="checkbox"/>	
Bone Disorders <input type="checkbox"/>	Fainting <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	
Tuberculosis <input type="checkbox"/>	Nervous Disorder <input type="checkbox"/>	Malignancies <input type="checkbox"/>	
Anemia <input type="checkbox"/>	HIV/Aids <input type="checkbox"/>	Adopted <input type="checkbox"/>	

Dental History

Have there ever been any injuries to the face, mouth, or teeth?	Yes ___ No ___
Have you ever had gum disease?	Yes ___ No ___
Have you been informed of any missing or extra permanent teeth?	Yes ___ No ___
Have you been previously evaluated or treated by an orthodontist?	Yes ___ No ___
Has anyone in your family had orthodontic treatment?	Yes ___ No ___
Please list any family members previously treated here _____	
What part of your orthodontic problem concerns you most? _____	

I consent to the taking of photographs and x-rays before, during and after treatment and to the use of the same by the doctor in scientific papers or demonstrations.

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____

ORTHODONTIC INSURANCE INFORMATION

We will be happy to assist you in determining your orthodontic insurance benefits, however all information must be completed and signed by the insured party.

Name of patient: _____

Date of birth: _____

Primary Insurance

Name of insured: _____		Date of birth: _____	
Home address: _____			
City/State/Zip: _____			
SS# of insured: _____		Home phone: _____	Work phone: _____
Employer: _____			
Work address: _____			
City/State/Zip: _____			
Insurance Company: _____			
Insurance Address: _____			
City/State/Zip: _____			
Telephone: (____) _____		Group# _____	
Office Use: LTM: _____		LTM Available: _____	

Secondary Insurance

Name of insured: _____		Date of birth: _____	
Home address: _____			
City/State/Zip: _____			
SS# of insured: _____		Home phone: _____	Work phone: _____
Employer: _____			
Work address: _____			
City/State/Zip: _____			
Insurance Company: _____			
Insurance Address: _____			
City/State/Zip: _____			
Telephone: (____) _____		Group# _____	
Office Use: LTM: _____		LTM Available: _____	

I understand that upon my request you will file any charges incurred at your office with my insurance company, however there is no guarantee of coverage and I am ultimately responsible for the account.

I hereby authorize release of any information relating to this claim and authorize payment directly to Dr. Neale.

Signature of insured party for primary insurance Date

Signature of insured party for secondary insurance Date