Patient Information

Date: ________________ Date of Birth: ___________________Age: ________________Sex:____________________________
Patient Name: ____Nickname: ____________________________________
Telephone: ____
Address: ____ City, State, Zip Code: _________________________________
Dentist: ____
School:____ Grade:____________________________
Patient's hobbies or interests:____

Responsible Party Information

Father __________________________SS#__________________
Birthday: ____________________________
Employer: ____
Work Telephone:____
Occupation: _________________ No. Years Employed: ______
Address:____
City:____________________________ State_____Zip ________
Email:____
Marital Status: Single ☐ Married ☐ Divorced ☐

Mother __________________________SS#________________
Birthday: ______________________
Employer:____
Work Telephone:____
Occupation:________________ No. Years Employed: ______
Address: ____
City: ____________________ State______ Zip ____________
Email:____
Marital Status: Single ☐ Married ☐ Divorced ☐

If patient is a minor, please give legal guardian____
Name, phone #, and address of nearest relative not living with you:____
____
Whom may we thank for referring you to our office?

Medical Information

Physician's Name:____
Has Patient ever been under the care of a physician for serious illness? Yes ☐ No ☐
If yes, please explain:____
Have tonsils and adenoids been removed? What age?__________ Yes ☐ No ☐
Is patient pregnant? Yes ☐ No ☐
List any allergies or medications now being taken: ____

Has patient experienced any of the following:

Glaucoma	☐	**Epilepsy**	☐	**High Blood Pressure**	☐
Diabetes	☐	**Asthma**	☐	**Low Blood Pressure**	☐
Pneumonia	☐	**Kidney Problems**	☐	**Circulatory Problems**	☐
Heart Trouble	☐	**Endocrine Problems**	☐	**Radiation Treatment**	☐
Rheumatic Fever	☐	**Prolonged Bleeding**	☐	**Arthritis**	☐
Bone Disorders	☐	**Fainting**	☐	**Hepatitis**	☐
Tuberculosis	☐	**Nervous Disorder**	☐	**Malignancies**	☐
Anemia	☐	**HIV/Aids**	☐	**Adopted**	☐

Has the patient reached puberty?
Girls: Has she started menstruation? Yes ☐ No ☐ If yes, Month/Year___________________
Boys: Secondary Sex Characteristics: Hair development? Yes ☐ No ☐
Please complete the following information as accurately as possible to help us evaluate family growth pattern:
Father: Height_____________Mother: Height_______________
Patient: Height_____________ Patient: Weight______________

Dental History

Have there ever been any injuries to the face, mouth, or teeth? Yes ☐ No ☐____
Has patient ever sucked their fingers or thumb? Yes ☐ No ☐____
Is patient a mouth breather? While awake? Yes ☐ No ☐____
While asleep? Yes ☐ No ☐____
Have you been informed of any missing or extra permanent teeth? Yes ☐ No ☐____
Has patient been previously evaluated or treated by an orthodontist? Yes ☐ No ☐____
Has either parent had orthodontic treatment? Yes ☐ No ☐____
Please list any family members previously treated here____
What part of your child's orthodontic problem concerns you most?____
Patient's attitude toward orthodontic treatment: wants treatment treatment is necessary unwilling but agrees uncooperative
Additional information which you feel would help make your child's association with us more enjoyable_____________________________
____

I understand that where appropriate, credit bureau reports may be obtained. I consent to the taking of photographs and x-rays before, after and during treatment and to the use of same by the doctor in scientific papers or demonstrations.

Signature of Parent/Guardian:____

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**