KIEFFER ORTHODONTICS
— A TEAM APPROACH —

PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____/_____/_____ AGE_____
LAST FIRST MIDDLE INITIAL

MALE_____ FEMALE_____ SOCIAL SECURITY_____ EMAIL ADDRESS_____

ADDRESS_____ CITY_____ STATE_____ZIP_____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

REFERRED BY_____ OTHER FAMILY MEMEBERS SEEN BY US_____

WHO IS ACCOMPANYING THE PATIENT TODAY? _____ RELATION _____

RESPONSIBLE PARTY

NAME_____ DATE OF BIRTH_____/_____/_____ RELATION_____
LAST FIRST MIDDLE INITIAL

ADDRESS_____ CITY_____ STATE_____ZIP_____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

SOCIAL SECURITY_____ EMAIL ADDRESS_____OCCUPATION_____

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME_____ PHONE NUMBER_____

CLAIMS ADDRESS_____ ORTHODONTIC COVERAGE? YES or NO

INSURED'S NAME_____ DATE OF BIRTH_____/_____/_____ RELATION_____

INSURED'S EMPLOYER_____ INSURED'S SOCIAL SECURITY #_____

SUBSCRIBER ID_____ INSURANCE GROUP/POLICY #_____

ASSIGNMENT OF BENEFITS

I understand that my contract for orthodontic coverage is between the insurance carrier and myself. I am also aware that Kieffer Orthodontics will bill my insurance carrier as a courtesy and that the ultimate responsibility for charges on my account are mine. I understand that my payable insurance benefits will be reimbursed to me as the services are rendered in most cases.

_____ _____

Signature of Patient/Parent/Guardian Date

DENTAL INFORMATION

Dentist's Name_____ Dentist's Phone #_____

What are the main reasons for your orthodontic evaluation? _____

Are you happy with your smile? If not, what would you like to change? _____

Have you been evaluated for orthodontic treatment in the past? If yes, explain: _____

Have you had difficulty related to previous dental work? If yes, explain: _____

Do you experience pain/discomfort in the jaw joint (TMJ)? If yes, explain: _____

Has there been any injury to your mouth, teeth or chin? If yes, explain: _____

Is your current dental health good, fair or poor?_____

Do you breathe through your mouth? If so, while sleeping or when awake? _____

Are you aware of any missing or extra permanent teeth? _____

Do you still have your wisdom teeth?_____

Do you have any speech problems?_____

Do you have any sleep issues? _____

MEDICAL INFORMATION

Physician's Name_____ Physician's Phone #_____

Are you under the care of a physician? If yes, explain: _____

Is your current medical health good, fair or poor?_____

Please list any serious medical conditions:_____

Please list any medications you are taking:_____

Please list any known allergies, including jewelry/metal & latex: _____

Check any of the following diseases or medical conditions that may apply:

____Abnormal Bleeding	____Diabetes	____Hepatitis	____Rheumatic/Scarlet Fever
____AIDS	____Difficulty Breathing	____Herpes/Fever Blisters	____Seizures
____Alcohol/Drug Abuse	____Emphysema	____High Blood Pressure	____Shingles
____Anemia	____Epilepsy	____HIV	____Sickle Cell Disease
____Arthritis	____Fainting Spells	____Hospitalized	____Sinus Problems
____Artificial Bones/Joints	____Frequent Headaches	____Kidney Problems	____Sleep Apnea
____Asthma	____Glaucoma	____Liver Disease	____Stroke
____Blood Transfusion	____Hay Fever	____Low Blood Pressure	____Thyroid Problems
____Cancer/Chemotherapy	____Heart Attack/Surgery	____Mitral Valve Prolapse	____Tuberculosis (TB)
____Colitis	____Heart Murmur	____Pacemaker	____Ulcers
____Congenital Heart Defect	____Hemophilia	____ Psychiatric Problems	

RELEASE

The information I have provided on this form is correct to the best of my knowledge and I understand it will be held in the strictest of confidence. I understand it is my responsibility to inform Kieffer Orthodontics of any changes in the patient's financial or medical/dental status. I authorize Kieffer Orthodontics to perform any necessary dental services needed during the patient's diagnosis and treatment. I understand that I am responsible for all charges incurred for services rendered, regardless of whether my insurance company reimburses me. I am aware that diagnostic imaging is taken at the initial exam for no charge at that time in order to render the best treatment plan, however, fees will apply for the imaging when treatment is initiated and/or if the images are taken elsewhere. I further agree that in the case of nonpayment, I am responsible for the cost of collection and/or legal fees should such action be required.

_____ _____

Signature of Patient/Parent/Guardian Date