Patient History & Information – Orthodontic Consultation

Patient Name____ **Birth Date**_________________________
Last Name First name Nickname
Home Address_______________________________________ **Town**_______________________ **Zip**___________________

Phone ___________________________ _____________________________ ___________________________________
Home Work Cell
Email Address_________________@________________________**School Attending or Occupation** __________________________

Physician & Phone _________________________________**General Dentist & Phone**_____________________________________

Has patient had an orthodontic consultation before? Where? ____

Have any other family members been seen in this office? Please list. ____

Whom may we thank for referring you to our orthodontic practice?___________________________

Parent Information (Minors only)

	Father	Mother
Full name	___________________________________	_______________________________________
Date of Birth	___________________________________	_______________________________________
SSN	___________________________________	_______________________________________
Occupation	___________________________________	_______________________________________
Business Tel	___________________________________	_______________________________________

Marital Status of parents (circle): married separated/divorced single

Medical History

Does the patient have or has he/she ever had : (please circle)

Heart murmur / mitral valve prolapse / other heart defects…	Yes	No	Rheumatic fever ……………………..	Yes	No
Mental Illness………………………………………………	Yes	No	Nervous disorder……………………..	Yes	No
Asthma / other respiratory disease…………………………	Yes	No	Bleeding Disorders…………………..	Yes	No
Anemia………………………………………………………	Yes	No	Allergies……………………………..	Yes	No
Diabetes……………………………………………………	Yes	No	Tuberculosis…………………………	Yes	No
HIV…………………………………………………………	Yes	No	Convulsions/epilepsy………………..	Yes	No
Kidney Disease……………………………………………	Yes	No	Hepatitis or liver disease……….……	Yes	No

Is patient allergic to penicillin, aspirin, or any other medication…………………………………………………Yes No

Is patient taking any medication at the present time?.. Yes No

Is patient under medical care now?... Yes No

Has patient ever had an unfavorable reaction from previous dental or medical care?... Yes No

Any previous hospitalizations?.. Yes No

Date of last medical examination…………____

Date of last dental examination……………____

If any of the above answers are yes, please explain:

I hereby authorize Dr. Christian Miller to render any services deemed necessary in the orthodontic treatment of
____ after consent by parent.

Date:___________________________ Signature of parent or guardian______________________________________

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

Richard L. Shulman, DMD, PC
Christian E. Miller, DDS
Plainview, NY (516) 932-1101

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100 Manetto Hill Road, Suite 208, Plainview, NY 11803
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Orthodontic Insurance Information

Is the patient covered by dental insurance? ……………………………… **YES** **NO**

Does the dental insurance include any orthodontic benefits?........ **YES** **NO**

Should treatment be advised, do you wish us to look into

your benefits and submit claims on your behalf?........................... **YES** **NO**

If yes to all, please provide the following and sign authorizations:

Insurance Company Name: ____

Insurance Company Claims Address:____

____

Insurance Company Phone: ____

Employer: ____

Insured's Name: ____

Insured's Social or Member ID(required): ____

Insured's Date of Birth**: ____**

Company Group #: ____

Relationship of patient to insured:(circle) **SELF** **SPOUSE** **DEPENDENT CHILD**

AUTHORIZATIONS (Required in order to authorize us to obtain plan information and submit on your behalf)

RELEASE OF INFORMATION

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with claims submitted.

X____

Patient/Guardian Signature Date

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Drs. Miller and Shulman. (All costs will be reviewed with guardian before submitting.)

X____

Subscriber Signature Date

FOR OFFICE USE ONLY (Please leave blank)

Date called __________________	**Pt's eligible Date** ______________________	**Ortho % Paid**__________________
ORTHO Max__________________	**Any used?**___________________________	**Deductible**____________________
Records count?_______________	**Pre-det required?**______________________	**Assign Ben?**__________________