Specialist in Orthodontics
for Adults & Children

PATIENT INFORMATION

____

Name: ____ Address: ____________________________________
First MI Last

City: _________________________ State: ______ Zip: __________ Phone: ___________________________________

Birthday: _____/______/______ Age: ___ Sex: M F Family Email: ____________________________________

RESPONSIBLE PARTY INFORMATION

FATHER / SELF / GUARDIAN INFORMATION

Name: ____

Address: ____

City: _____________________State: _______ Zip: _____________

Home #:___________________Work #:_____________________

Birthday: ____/____/_______ Marital Status: _______________

SS# ____

MOTHER / SPOUSE INFORMATION

Name: ____

Address: ____

City: _____________________State: _______ Zip: _____________

Home #:___________________Work #:_____________________

Birthday: ____/____/_______ Marital Status: _______________

SS# ____

DENTAL INSURANCE INFORMATION

Subscriber: _________________________________ DOB: _____/_____/_________ Relationship to Patient: ___________________________

Employer:______________________ Insurance Company: ________________________________ Subscriber ID#:________________________

Group #: _______________________________ Local #: __________________ Phone #: ____

Address: ____ City: _________________________________ State: ______________

Do you have dual insurance coverage*: YES NO *If yes, please enter information below

Subscriber: _________________________________ DOB: _____/_____/_________ Relationship to Patient: ___________________________

Employer:______________________ Insurance Company: ________________________________ Subscriber ID#: _______________________

Group #: _______________________________ Local #: __________________ Phone #: ____

Address: ____ City: _________________________________ State: ______________

Whom may we thank for referring you? (Circle)

Family Member Family Dentist Friend Web Site

5520 Medical Circle Madison, WI 53719 (608) 274-5714	800 Lincoln Avenue Stoughton, WI 53589 (608) 873-7888	4719 Farwell Street McFarland, WI 53558 (608) 838-8584	677 South Main Street DeForest, WI 53532 (608) 846-3600

HEALTH HISTORY

Patient's Name: ____

Patient Dentist: _________________________________ Last check up/cleaning: _______________________

Patient Physician: _______________________________ Date of Last Physical: _________________________

Allergic Reactions (***CIRCLE***)

Latex Aspirin Ibuprofen Metal Other: ____

Frequently Experienced (***CIRCLE***)

Headaches Fainting Clenching or Teeth Grinding Gagger Cheek, Tongue or Lip Chewing

TMJ Mouth Breather Tongue Thrust Speech Concerns Fever Blisters Finger Nail Biting

Other: ____

Diagnosed or Treated (***CIRCLE***)

Broken Bones Pregnancy Asthma/Hay Fever Jaundice Hepatitis Diabetes Blood Pressure

HIV/Aids Anemia/Hemophilia Epilepsy Drug Addiction Measles Blood Transfusion

**Joint Replacement/Implants **Rheumatic Fever/Arthritis **Heart Disease or Mitro Valve Prolapse

Radiation or Chemical Therapy Nervous/Emotional Problems Other: _________________________

** Does the patient require antibiotic pre-medication for dental treatment: YES NO

Prescription medications currently taking: (**Please list**)

1. ____________________________ Reason: ____
2. ____________________________ Reason: ____

INSURANCE ASSIGNMENT AND RELEASE – I, the undersigned assign directly to Greater Madison Orthodontics all insurance benefits, otherwise payable to me for services rendered. I also hereby authorize Greater Madison Orthodontics to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

____ ______________________________

Signature (Parent or Guardian if patient is a minor) **Date**