Patient Information

Date__________ LOCATION______________________ General Dentist _________________________

Patient's Name____
Last First Middle

Address____
Street City State Zip

Home Phone_________________ Pt's Work Phone ___________________ Cell Phone____________________

Birth Date _________ Parents/Guardians _____________________ ______________________ ___________
Mother Father Marital Status

Name of School _______________________________

Person responsible for Account - complete any information that is not the same as above or below

Name____ Social Security #_________________________
Last First Middle

Address____
Street City State Zip

Relationship to Patient________________________ Home # __________________ Cell #___________________

Employer__________________________ Occupation ______________________ Work #___________________

Email address________________________________

The below policy holder's signature authorizes the office of Alpine and Rafetto Orthodontics to affix my name to any and all claims or documents related to any and all orthodontic benefits due me and my dependents through my employment. I authorize payment of orthodontic benefits, otherwise payable to me, directly to the office of Alpine & Rafetto Orthodontics.

Dental / Orthodontic Insurance Information ***(DENTAL ONLY)***

1. Policy Holder's Name____________________________Signature___________________________________
   Policy Holder's Address____
   Employer____ Occupation____________________________
   Relationship to Patient_______________________ SSN __________________ Birth Date ______________
   Home #___________________ Work # _____________________ Cell #_____________________________
   ID number on card________________________________ Account # _______________________________
   Name of Insurance Company ____
   Telephone Number of Insurance Company ____

This BOX for office use only	Benefits:	Employee:	Covered	YES	NO
		Spouse:	Covered	YES	NO
		Age:	Ded:		
		Date__________	Initial____________		

2. Policy Holder's Name ___________________________ Signature __________________________________
   Policy Holder's Address ____
   Employer _______________________________________Occupation______________________________
   Relationship to Patient_____________________ SSN____________________ Birth Date ______________
   Home #______________________ Work #______________________ Cell #___________________________
   ID number on card_______________________________ Account #_________________________________
   Name of Insurance Company____
   Telephone Number of Insurance Company____

This BOX for office use only	Benefits:	Employee:	Covered	YES	NO
		Spouse:	Covered	YES	NO
		Age:	Ded:		
		Date__________	Initial____________		

Who may we **thank for referring** you to our office? ________________________________

List family members who have *completed treatment* or *are currently being treated* at our office:
____

Concerns that you would like orthodontist to addressed:________________________________
____

Patient's Health Information

Patient's Physician________________________________ Phone # ________________
List medications currently taking: ________________________________
Are there any medical conditions that we should know about? ________________________
____

Have you ever had any of the following diseases, medical problems or allergies? **(Circle Y or N)**

Y N Heart Murmur
Y N Rheumatic Fever
Y N Heart Surgery
Y N Pacemaker
Y N Mitral Valve Prolapsed
Y N Kidney problems
Y N Asthma / Arthritis
Y N Hepatitis
Y N Aspirin / Codeine
Y N Dental Anesthetics
Y N Psychiatric / Learning / Coordination problems
Y N Epilepsy / Seizures / Fainting Spells
Y N Diabetes / Tuberculosis (TB)
Y N HIV & AIDS
Y N Hemophilia / Abnormal bleeding
Y N Cancer / Chemotherapy / Radiation treatment
Y N Artificial bones / Joints
Y N Sinus / Breathing problems
Y N Adenoids / Tonsils removed
Y N Latex / Rubber Gloves
Y N Penicillin / Tetracycline / Erythromycin / Sulfa Meds

Are you aware of any other allergies? ________________________________
____

Female teens: Please indicated month and year menses started ________________________

Have you ever experienced pain, clicking, popping noises in your jaw joint? ________________
Have you ever had an injury to your mouth, teeth or chin? ________________________
Would you say your overall dental health is: GOOD FAIR POOR

I certify that I have read and understand the above questions. To the best of my knowledge, the above questions have been completely and accurately answered. A photocopy of this document may act as an original.

________________________________ ________________________
Signature of Responsible Party Date

Information Updates ________________________
Initials Date

Information Updates ________________________
Initials Date