Welcome

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SPECIALIST IN ORTHODONTICS
DROCONOR.COM

1

Child's Information

Today's Date: _____ Home Phone: _____

Name: _____ Cell Phone: _____

Birthdate: _____ Age _____ Nickname: _____ ☐ Male ☐ Female

Address: _____ How did you hear about our office? _____

City/State/Zip: _____ _____

Email Address: _____ Family Dentist: _____

2

Mother's Information (if patient is a child)

Name: _____

Address: _____

City/State/Zip _____

Wk. #: _____ Hm. #: _____

Employer: _____

Employer Address: _____

City/Zip: _____ SS #: _____

Email Address: _____

Custodial Parent? ☐Yes ☐No

Person responsible for account ☐Yes ☐No

Father's Information (if patient is a child)

Name: _____

Address: _____

City/State/Zip _____

Wk. #: _____ Hm. #: _____

Employer: _____

Employer Address: _____

City/Zip: _____ SS #: _____

Email Address: _____

Custodial Parent? ☐Yes ☐No

Person responsible for account ☐Yes ☐No

3

Primary Orthodontic Insurance

Orthodontic Coverage ☐ Yes ☐ No

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

SS #: _____

Policy Owner's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Signature on file for insurance claims _____

Secondary Orthodontic Insurance

Orthodontic Coverage ☐ Yes ☐ No

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

SS #: _____

Policy Owner's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Signature on file for insurance claims _____

4 Were you referred by your dentist? ☐Yes ☐No

What do you dislike about your teeth?

5 Have you had any of the following dental problems?

Y N Orthodontic Evaluation or Treatment
Y N Periodontal Treatment (Gum Disease)
Y N TMJ Treatment (Jaw Joint)
Y N Grinding Your Teeth
Y N Sounds in Your Jaw
Y N Jaw Pain When Opening or Closing
Y N Injuries to the Face, Head, Teeth
Y N Mouth Breathing
Y N Removal of Tonsils or Adenoids
Y N Sores or Lumps in Your Mouth
Y N Speech Problems
Y N Thumb or Finger Sucking

Are you allergic to any drugs or other substances?

_____

_____

Other: _____

_____

6 Have you had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	Diabetes
Y N	Allergic to any Drugs	Y N	Handicaps/Disabilities
Y N	Allergic to Latex/Metals	Y N	Hearing Impairment
Y N	Allergic to Plastic	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hepatitis
Y N	Any Operations	Y N	Hemophilia
Y N	Asthma	Y N	HIV+/AIDS
Y N	Cancer	Y N	Kidney/Liver Problems
Y N	Congenital Heart Defect	Y N	Rheumatic/Scarlet Fever
Y N	Convulsions/Epilepsy	Y N	Tuberculosis

Pleases discuss any other medical problems:

_____

_____

List drugs currently taking: _____

_____

7

I understand the following information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services. I have received a copy of this office's Notice of Privacy Practices.

Signature_____

Date_____

Summary