



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 _____

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

PRIMARY DENTAL INSURANCE - ORTHODONTIC COVERAGE? Yes No

INSURANCE COMPANY NAME _____ PHONE NUMBER _____

CLAIMS ADDRESS _____ INSURED'S EMPLOYER _____

INSURED'S NAME _____ DATE OF BIRTH ____/____/____ RELATION _____

INSURED'S SOCIAL SECURITY # _____ - _____ - _____ INSURANCE GROUP/POLICY # _____

SECONDARY DENTAL INSURANCE - ORTHODONTIC COVERAGE? Yes No

INSURANCE COMPANY NAME _____ PHONE NUMBER _____

CLAIMS ADDRESS _____ INSURED'S EMPLOYER _____

INSURED'S NAME _____ DATE OF BIRTH ____/____/____ RELATION _____

INSURED'S SOCIAL SECURITY # _____ - _____ - _____ 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

OVER →

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? _____

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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Heart Attack/Surgery | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Phen-Phen | |

RELEASE

I understand that the information that I have given today is correct to the best of my knowledge and that it will be held in the strictest of confidence. I understand that 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 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