About You

Please circle or check off appropriate areas.

Today's Date: _____

[ ] Male
[ ] Female

Your Name:

_____
LAST FIRST MI

Nickname: _____

SS#: _____-_____-_____

Birth Date: _____/_____/_____

Age: _____

Employer: _____

Employer's Address: _____

_____

How long there? _____

Occupation: _____

Primary#: _____
Home/Cell/Business

Secondary#: _____
Home/Cell/Business

Email: _____

Home Address:

_____
APT#

_____
CITY STATE ZIP

General Dentist: _____

Address: _____

_____
CITY STATE ZIP

Phone#: _____

Last Visit Date: _____

Whom may we thank for referring you? _____

_____

Other family members seen by us: _____

_____

Marital Statues:

[ ] Single
[ ] Married
[ ] Widowed
[ ] Divorced
[ ] Separated

Spouse's Information

Name: _____

Birth Date: _____/_____/_____

Primary Phone#: _____
Home/Cell/Business

Secondary Phone#: _____
Home/Cell/Business

Employer: _____

SS#:_____-_____-_____

Email: _____

Person Responsible for Account

Name: _____

Relationship: _____

Address: _____

_____
CITY STATE ZIP

Primary Phone#: _____
Home/Cell/Business

Primary Orthodontic Insurance

Orthodontic coverage? [ ] Yes [ ] No

Insurance Company Name: _____

Insurance Company Address: _____

_____
CITY STATE ZIP

Insurance Company Phone #: _____

Policy Holder/Subscriber ID (SSN or ID#):

_____

Plan/Group Number: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: _____/_____/_____

Policy Owner's SS#: _____-_____-_____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance

Orthodontic coverage? [ ] Yes [ ] No

Insurance Company Name: _____

Insurance Company Address: _____

_____
CITY STATE ZIP

Insurance Company Phone #: _____

Policy Holder/Subscriber ID (SSN or ID#):

_____

Plan/Group Number: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birth Date: _____/_____/_____

Policy Owner's SS#: _____-_____-_____

Policy Owner's Employer: _____

Emergency Contact

Name: _____

Address: _____

_____
CITY STATE ZIP

Primary Phone #: _____

What are the main concerns that you would like Orthodontics to address?

_____

_____

_____

_____

_____

Have you ever been evaluated for or had orthodontic treatment before? [ ] Yes [ ] No

Have there been any injuries to the face, mouth, teeth, or chin? [ ] Yes [ ] No

Have you been informed of any missing or extra teeth? [ ] Yes [ ] No

Have you ever had any pain/tenderness in your Jaw joint (TMJ/TMD)? [ ] Yes [ ] No

Do you brush you teeth daily? [ ] Yes [ ] No
Floss your teeth daily? [ ] Yes [ ] No

Physician: _____
Phone#: _____
Date of last Visit: _____

Are you currently under the care of a physician?
[ ] Yes [ ] No
Please explain: _____
_____
_____

Are you taking Fosamax? [Y] [N]
Are you taking Bisphosphonates? [Y] [N]
For women:
Are you taking birth control pills? [ ] Yes [ ] No
Are you pregnant? (If yes, week#_____) [ ] Yes [ ] No
Are you nursing? [ ] Yes [ ] No

Please describe your current physical health:
[ ] Good [ ] Fair [ ] Poor
Please describe your current dental health:
[ ] Good [ ] Fair [ ] Poor
Do you like your smile? [ ] Yes [ ] No
Do your gums ever bleed? [ ] Yes [ ] No
Do you smoke or use tobacco in any form? [ ] Yes [ ] No
Do you have speech problems? [ ] Yes [ ] No
Do you generally breathe through your mouth?
[ ] Yes [ ] No
When awake? [ ] Yes [ ] No
When asleep? [ ] Yes [ ] No

Please list all drugs you are currently taking:
_____
_____
_____

Please list all drugs you are allergic to:
_____
_____
_____

Have you ever had any of the following medical problems?

[Y] [N] Anemia
[Y] [N] Allergy to any Drugs
[Y] [N] Allergy to Latex/Metals
[Y] [N] Allergy to Plastic
[Y] [N] Any Hospital Stays

Continued....

[Y] [N] Any Operations
[Y] [N] Asthma/Arthritis
[Y] [N] Cancer/Chemotherapy
[Y] [N] Congenital Heart Defect
[Y] [N] Convulsions/Epilepsy/Fainting Spells
[Y] [N] Artificial Bones/Joints/Valves
[Y] [N] Diabetes
[Y] [N] Handicaps/Disabilities
[Y] [N] Hearing Impaired
[Y] [N] Heart Murmur
[Y] [N] Hemophilia/Abnormal Bleeding
[Y] [N] Hepatitis
[Y] [N] HIV+/AIDS
[Y] [N] Kidney/Liver Problems
[Y] [N] Rheumatic/Scarlet Fever
[Y] [N] Tuberculosis (TB)
[Y] [N] Blood Transfusion
[Y] [N] Difficulty Breathing
[Y] [N] Drug/Alcohol Abuse
[Y] [N] Emphysema/Glaucoma
[Y] [N] Fever Blisters? Herpes
[Y] [N] Heart Attack/Stroke
[Y] [N] Heart Murmur
[Y] [N] Heart Surgery/Pacemaker
[Y] [N] High/Low Blood Pressure
[Y] [N] Mitral Valve Prolapse
[Y] [N] Psychiatric Problems
[Y] [N] Rheumatic/Scarlet Fever
[Y] [N] Shingles
[Y] [N] Sinus Problems
[Y] [N] Ulcers/Colitis
[Y] [N] Venereal Disease
[Y] [N] Sickle Cell/Traits

Please discuss any medical problems that you have had:
_____
_____
_____
_____
_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my my medical status. I authorize the dental staff to perform any necessary services I may need.

You are responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____
Signature

_____
Date

Voice Message Communication

- ☐ *I authorize your office to leave voice messages for me on my home phone revealing the identity of your office. I also authorize you to leave voice messages concerning appointments, scheduling, and request for call back without mentioning specifics. I will accept responsibility for the privacy issues that may arise.*

- ☐ *I do not authorize you to leave any voice messages for me from the office.*

Signature: _____

Date: _____

Agreement to Receive Electronic Communication

Marble Hill Orthodontics – Ryan Walter, D.M.D., LLC

Patient Name: _____

Date of Birth: _____

I agree that the Marble Hill Orthodontics – Dr. Ryan Walter, D.M.D. may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: (908) 859-4555

Email Address (PLEASE PRINT CLEARLY):

_____

Signature: _____

Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Marble Hill Orthodontics to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

Marble Hill Orthodontics – Dr. Ryan Walter, D.M.D., LLC

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ *Individual refused to sign*
- ☐ *Communications barriers prohibited obtaining the acknowledgement*
- ☐ *An emergency situation prevented us from obtaining acknowledgement*
- ☐ *Other (Please Specify)*

_____

_____

_____