Town & Country
ORTHODONTICS

FILL OUT THE FORM COMPLETELY, PLEASE PRINT CLEARLY

Today's Date:

PATIENT INFORMATION

Full Name: ______ First ______ Middle ______ Last ______ Nickname

○ Male ○ Female DOB: ______ (MM/DD/YYYY) ○Single ○Divorced ○Married ○Separated ○Child/Minor: ______ (Name of Legal Guardian)

Home Address: ______ Street ______ City ______ State ______ Zip Code

Home Phone: ( ) ______ Cell Phone: ( ) ______ Work Phone: ( ) ______

School Attending: ______ E-mail: ______ *(We do not distribute your e-mail address)*

Hobbies: ______

Whom may we thank for referring you to our office? ○Family/Friends ______

○ Google ○ Facebook/Instagram ○Website ○Dental Insurance ○Dentist Referral: ______

RESPONSIBLE PARTY INFORMATION

Full Name: ______ First ______ Middle ______ Last DOB: ______ (MM/DD/YYYY)

Relationship to Patient: ○ Self ○ Father ○ Mother ○ Other: ______ E-Mail: ______ *(We do not distribute your e-mail address)*

Home Address: ______ Street (if different than above) ______ City ______ State ______ Zip Code

Home Phone: ( ) ______ (if different than above) Cell Phone: ( ) ______ (if different than above) Work Phone: ( ) ______ (if different than above)

Employer: ______ Occupation: ______

○ Single ○ Married ○ Divorced ○ Separated ○ Widow Social Security No: ______

Spouse: ______ First ______ Middle ______ Last DOB: ______ (MM/DD/YYYY)

Relationship to Patient: ○ Self ○ Father ○ Mother ○ Other: ______ E-Mail: ______ *(We do not distribute your e-mail address)*

Employer: ______ Occupation: ______

NOTE: The following information is requested so that we may communicate properly with the people involved with your child's treatment

With whom does the patient live? ______

Who may receive routine information about treat progress? ______

PLEASE PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD TO ENSURE ACCURATE BILLING

DENTAL INSURANCE INFORMATION

○ I do not have dental insurance

Do you have secondary dental coverage? ○ Yes ○ No

Insurance Company: ______ Group/Policy #: ______

Insurance Claims Address: ______ Street ______ City ______ State ______ Zip Code

Insurance Co. Phone: ( ) ______ Insured's Social Security No: ______

Insured's Full Name: ______ Insured's DOB: ______ (MM/DD/YYYY)

Insured's Relationship to Patient: ______

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First Initial: Last Name:

MEDICAL HISTORY

Physician: ______ ***Date of Last Visit:*** ______

Please indicate Yes or No: (If ***Yes***, please fill in details)

- ○ **Yes** ○ **No** Are you currently taking any medication(s)? ______
- ○ **Yes** ○ **No** Are you allergic to any medication(s)? ______
- ○ **Yes** ○ **No** Is there a history of any major illness? ______
- ○ **Yes** ○ **No** Have you seen a physician in the last 12 months? If so, why? ______
- ○ **Yes** ○ **No** Have you had any operations? If so, please list. ______
- ○ **Yes** ○ **No** Have you ever been involved in a serious accident? ______
- ○ **Yes** ○ **No** Female Only: Has menstruation started? ______
- ○ **Yes** ○ **No** Female Only: Are you or could you be pregnant? ______

Please ☑ any of the medical conditions listed below that the patient has had, or may currently have:

☐ Abnormal bleeding/Hemophilia	☐ Anemia	☐ Arthritis
☐ Diabetes	☐ HIV / Aids	☐ Pneumonia
☐ ADD/ADHD	☐ Heart Problems	☐ Gastrointestinal Disorders
☐ Hepatitis/Liver problems	☐ High Blood Pressure	☐ Tumor or cancer
☐ Heart Problems	☐ Epilepsy / Nervous Disorders	☐ Dizziness/Fainting Problems
☐ Bone Disorders	☐ Rheumatic Fever	☐ Kidney Problems
☐ Tuberculosis	☐ Radiation/Chemotherapy	☐ Heart Murmur
☐ Prolonged Bleeding	☐ Asthma or Hayfever	☐ Herpes

Are there any other medical conditions NOT listed on this form we need be aware of?

______

Is there any information that would better help us treat the patient?

______

DENTAL HISTORY

General Dentist: ______ ***Date of Last Visit:*** ______

What concerns you most about your teeth? ______

- ○ **Yes** ○ **No** Are you sensitive or self-conscious about your teeth? ______
- ○ **Yes** ○ **No** Have you ever seen an orthodontist? If so, when? ______
- ○ **Yes** ○ **No** Have you experienced any unfavorable reaction to dentistry? ______
- ○ **Yes** ○ **No** Are you presently in any dental pain? ______
- ○ **Yes** ○ **No** Have you had any injuries to face, mouth, or teeth? ______
- ○ **Yes** ○ **No** Are you missing, lost or chipped any teeth? ______
- ○ **Yes** ○ **No** Have you had any permanent teeth extracted? If so, when? ______
- ○ **Yes** ○ **No** Is any part of your mouth sensitive to temperature? If so, where? ______
- ○ **Yes** ○ **No** Do your gums bleed when brushing? ______
- ○ **Yes** ○ **No** Do you have any type of thumb or tongue habit? ______
- ○ **Yes** ○ **No** Do you have speech problems, or are you in speech therapy? ______
- ○ **Yes** ○ **No** Are you a mouth breather? ______
- ○ **Yes** ○ **No** Do you have sleep apnea? ______
- ○ **Yes** ○ **No** Do you clench or grind your teeth during the day? ______
- ○ **Yes** ○ **No** Do you experience “tension” headaches? ______
- ○ **Yes** ○ **No** Have we treated any family members? ______
- ○ **Yes** ○ **No** What is your attitude toward receiving orthodontic treatment? ______
- ○ **Yes** ○ **No** Height of parents? *Mom*__________ / *Dad*__________ ______
- ○ **Yes** ○ **No** Are you aware that some appointments will be during school hours? ______

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First Initial: **Last Name:**

ASSIGNMENT OF BENEFITS

Financial Responsibility
I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Town and Country Orthodontics and/or its affiliated entities for any charges not covered by dental benefits. It is my responsibility to notify Town and Country Orthodontics of any changes in my dental coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Town and Country Orthodontics and/or my dental insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, that I am accepting financial responsibility as explained above for all payment for dental services and/or supplies received. **Initials** __________

Assignment of Benefits
I authorize direct remittance of payment of all insurance benefits to Town and Country Orthodontics for all covered dental services and supplies provided to me during all courses of treatment and care provided by Town and Country Orthodontics and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effects for so long as I am being treated or cared for by Town and Country Orthodontics, and will constitute a continuing authorization, maintained on file with Town and Country Orthodontics, which will authorize and allow for direct payment to Town and Country Orthodontics of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Town and Country Orthodontics. **Initials** __________

Authorization to Release Information
I authorize the release of any medical or dental information to my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related dental services and/or supplies provided to me by Town and Country Orthodontics. A copy of this authorization will be sent to my insurance carrier(s), or other dental entity, if requested. The original authorization will be kept by Town and Country Orthodontics. **Initials** __________

Benefits of Orthodontics
Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Domann and Dr. Orfanos to perform a complete orthodontic evaluation.

Signature of Patient **Date**

Printed Name

Signature of Guardian (if a minor) **Date**

Printed Name