

Michael D. Collins, D.D.S.
Welcome to Our Office

Date _____ 20 _____

Date of Birth _____

Age _____ Sex Male Female

Telephone Number _____

Patient's Name _____

Name Patient prefers to be called _____

Home Address _____ City _____ Zip Code _____

Patient's Dentist _____ Physician _____

Whom may we thank for referring you to our office? _____

INFORMATION FOR ADULT PATIENTS

Employer _____ Social Security # _____

Name of Spouse _____ Patient's Business Phone (____) _____

Spouse's Employer _____ Spouse's Business Phone (____) _____

INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

School _____ Grade _____

Parent's Marital Status Married Divorced Widowed Single

MOTHER'S INFORMATION

FATHER'S INFORMATION

Name _____

Name _____

Home Phone (____) _____ Work (____) _____

Home Phone (____) _____ Work (____) _____

Cell Phone _____

Cell Phone _____

Email Address _____

Email Address _____

Date of Birth _____

Date of Birth _____

Employer _____

Employer _____

Social Security # _____

Social Security # _____

MEDICAL HISTORY

Is the Patient in good health? Yes No Reason _____

Any major or unusual illnesses? Yes No Explain _____

Currently under physician's care? Yes No Reason _____

Currently taking medication? Yes No List _____

Any allergies or drug sensitivity? Yes No List _____

DENTAL HISTORY

Date of last dental check-up: _____

Have there ever been any injuries to the face, mouth, or teeth? Yes No _____

Is there a history of thumb/finger sucking? Until what age? Yes No _____

Are you a mouth breather? While awake? Yes No _____

While asleep? Yes No _____

Have you been informed of any missing or extra permanent teeth? Yes No _____

Have you consulted or been treated by an orthodontist previously? Yes No _____

Did either parent have orthodontic treatment? Yes No _____

Other family members seen for a New Patient Exam? _____

Do you have pain in the jaw joints? Right Left Do you have popping or cracking of the jaw joints? Right Left

When did this begin? _____

What part of your child's (your) orthodontic problem concerns you the most? _____

Patient's attitude toward orthodontic treatment: wants treatment treatment if necessary unwilling but agrees uncooperative

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record I will so inform this practice. I the undersigned understand that where appropriate, credit bureau reports may be obtained. I hereby authorize the taking of x-rays and other records for an initial diagnosis if needed.

Signature (Patient/Responsible Party)

Date

ORTHODONTIC INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Employed by: _____ Telephone: _____

Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Is patient covered under another dental plan? If so, please complete the following information:

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Employed by: _____ Telephone: _____

Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____ Telephone: _____

City: _____ State: _____ Zip: _____

I hereby authorize release of any information relating to this claim.

Signature Date _____

I hereby authorize payment on insurance benefits directly to the below named orthodontist.

Signature Date _____

For office use only: Conf Date: _____ Benefit Amt: _____ Deductible: _____

Pymt. Interval: M Q S A Other _____