STEWART ORTHODONTICS

Patient Name:____________ Likes to be called:__________ ☐ Male ☐ Female Date of Birth:__________

Age:______ School:____________ Grade:________ Phone Number:__________

Address:____________ City and Zip:____________ Hobbies/Sports:____________

Physician:____________ Dentist:____________ Date of last dental visit:__________

Whom may we thank for referring you:________________________

List brothers/sisters with age:________________________

Patient's/Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mother/Wife:________________ Employer:____________

Date of Birth:____________ Social Security Number:________________

Address:____________ City:__________ State:_____ Zip:_______

Home Phone:____________ Work Number:____________ Ext.:_______

Father/Husband:________________ Employer:____________

Date of Birth:____________ Social Security Number:________________

Address:____________ City:__________ State:_____ Zip:_______

Home Phone:____________ Work Number:____________ Ext.:_______

Primary Insurance: Orthodontic Coverage: ☐ Yes ☐ No Employer:____________

Insurance Co. Name:____________ Address:____________ City:__________

State:________ Zip:______ Phone Number:____________ Group Number:__________

Policy Owner:____________ Relationship to Patient:____________ Date of Birth:__________

Secondary Insurance: Orthodontic Coverage: ☐ Yes ☐ No Employer:____________

Insurance Co. Name:____________ Address:____________ City:__________

State:________ Zip:______ Phone Number:____________ Group Number:__________

Policy Owner:____________ Relationship to Patient:____________ Date of Birth:__________

Medical Information:

Abnormal Bleeding	Y	N	Diabetes	Y	N	Asthma	Y	N	Thumb Habit	Y	N
Fainting	Y	N	Hepatitis	Y	N	Epilepsy	Y	N	Nail Biter	Y	N
Kidney/Liver Problems	Y	N	Hiv +/Aids	Y	N	Heart Disease	Y	N	Lip Biter	Y	N

Drug Allergy or Sensitivity________________ Have tonsils or adenoids been removed?____________

Please discuss any medical problems the patient has:________________________

Please list all medications the patient is currently taking:________________________

Have there been any injuries to the face, mouth, teeth, or chin?________________________

What is your main concern in seeking orthodontic care?________________________

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 confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the insurance company to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered and that I'm responsible for payment of services rendered and any co-payment and deductibles that my insurance does not cover. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

________________________ ________________

Signature Date