PATIENT HISTORY FORM

Date _____

PLEASE PRINT IN INK

or fill out on-line at

OrthoSouth.com

ORTHO SOUTH SMILE ON

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205.664.4140

PATIENT INFORMATION

First Name:_____ Last Name:_____ Preferred Name: _____ Sex: _____ Birthdate:_____ Age:_____

Address: _____ City:_____ State:_____ Zip:_____ Home Phone:_____

School (if student): _____ Grade: _____ ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widow(er)

Employed By: _____ Occupation:_____ Business Phone: _____

Email: _____ Cell Phone: _____ Fax: _____

SS#: _____ Name of Dentist: _____ Date of last cleaning: _____

Previously examined by an orthodontist? ❍ Yes ❍ No If yes, by whom?_____ Date: _____

What is the primary concern of the patient's smile? _____

What was the deciding factor in giving us a call? _____

Related patients or friends that are currently or have been under our care? _____

Name and age of siblings: _____

IF PATIENT IS A MINOR PLEASE COMPLETE THE SECTION BELOW. IF NOT, SKIP TO INSURANCE SECTION.

PARENT/GUARDIAN 1 INFORMATION

Name:_____

Address (if different from patient): _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Fax: _____

Bdate:_____ SS#:_____

Employer:_____

Employer's Address: _____

City:_____ State:_____ Zip:_____

PARENT/GUARDIAN 2 INFORMATION

Name:_____

Address (if different from patient): _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Fax: _____

Bdate:_____ SS#:_____

Employer:_____

Employer's Address: _____

City:_____ State:_____ Zip:_____

If divorce is involved, who is the custodial parent? _____

May patient information be released to the non-custodial parent? ❍ Yes ❍ No

INSURANCE INFORMATION

Do you have orthodontic coverage? ❍ Yes ❍ No Name of primary insurance company? _____

Address: _____ City:_____ State:_____ Zip:_____

Phone Number: _____ Group Policy #: _____ ID#: _____

Insured's Name: _____ Relationship to patient: _____ Insured's birthdate: _____

Insured's SS#: _____ Insured's Employer: _____

Lifetime Max: _____ Group Name: _____

Name of secondary insurance company: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone Number: _____ Group Policy #: _____ ID#: _____

Insured's Name: _____ Relationship to patient: _____ Insured's birthdate: _____

Insured's SS#: _____ Insured's Employer: _____

Lifetime Max: _____ Group Name: _____

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GENERAL INFORMATION

How do you prefer to receive appointment reminders? ❍ Email:_____ ❍ Call:_____ ❍ Text:_____ (text rates may apply)

How did you hear about our office? (Check all that apply) ❍ Dentist ❍ Patient ❍ Google ❍ Facebook ❍ Instagram ❍ Other:_____

RESPONSIBLE PARTY

Person responsible for the account:_____ Birthdate:_____

Relationship to Paitent: _____ If patient is a minor, do you havre legal custody? ❍ Yes ❍ No ❍ Single ❍ Married ❍ Divorced ❍ Widow(er)

Billing address:_____ City:_____ State:_____ Zip:_____

Phone: _____ Work Phone: _____

Employer:_____ Occupation:_____# Years at Current Employer:_____

Patient Email:_____ Mom Email: _____

Dad Email:_____ Other Email: _____

PATIENT MEDICAL HISTORY please check if patient has or has had:

- ❍ Heart Murmer
- ❍ Mitral Valve Prolapse
- ❍ Heart Disease/Disorder
- ❍ High Blood Pressure
- ❍ Low Blood Pressure
- ❍ Bone Disorders
- ❍ Joint Replacement or Implants
- ❍ Anemia/Blood Disorders
- ❍ Prolonged Bleeding
- ❍ Rheumatic Fever
- ❍ Arthritis
- ❍ Immune System Problems
- ❍ Recent Weight Gain/Loss
- ❍ HIV/Aids
- ❍ STD
- ❍ Hepatitis or Live Disease
- ❍ Kidney Disease
- ❍ Diabetes
- ❍ Tumors/Growths
- ❍ Cancer Treatement
- ❍ Tonsils or Adenoids Removed
- ❍ Tonsillitis
- ❍ Earaches
- ❍ Sinus Trouble
- ❍ Asthma/Hay Fever
- ❍ Respiratory Problems
- ❍ Thyroid/Parathyroid Problems
- ❍ Brain Injury
- ❍ Seizures
- ❍ Fainting/Dizziness
- ❍ Emotional Problems
- ❍ Psychiatric Care
- ❍ Glaucoma

Are you allergic to or have you had any allergic reactions to the following?

- ❍ Local Anesthetics (e.g. Novacaine)
- ❍ Penicillin (or other antibiotics)
- ❍ Sulfa Drugs
- ❍ Metals (e.g. nickel, mercury, etc.)
- ❍ Latex Rubber
- ❍ Other (please list below)

_____
_____
_____

On items checked "Yes", please provide us with a more detailed description:_____

List any drugs or medications now being taken: _____

Is patient presently under a physician's care? ❍ Yes ❍ No Reason if Yes: _____

Have you ever been told to pre-medicate before dental appointments? ❍ Yes ❍ No Reason if Yes:_____

Name of Physician: _____

AUTHORIZATION & RELEASE

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of all medical records on the above named patient to the referring dentist, physician or other health care provider, as well as information and records necessary for processing insurance claims. I authorize the release of financial information for collection and records transfer purposes. I authorize the necessary diagnostic tests and any orthodontic treatment deemed necessary to be performed by or under the direction of Dr. Boggan and/or associates of Orthodontics South, PC. I give my permission for any photographs, x-rays or study models to be updated during treatment and to be used for displays in our office, on our website, at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I hereby authorize the necessary credit information to be obtained by Orthodontics South, PC or other third party company for the purposes of consideration of payment options. We are sorry that we can not accept divorce decrees as assignments of responsibility for a child's orthodontic account. I authorize the orthodontist to recontour any misshaped teeth and for any progress x-rays or records to be taken at their discretion. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Signature: _____ Relationship to Patient: _____ Date: _____