SHINE ORTHODONTICS

New Patient Intake

Patient Information

Patient Name:_____ Sex:_____

Date of Birth:_____ Age:_____ SSN:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Primary Telephone:_____ Type:_____ Okay to leave message?:_____

Email Address:_____

School:_____ Grade:_____

Sports, hobbies, extracurricular activities:_____

Responsible Party Information

Responsible Party Name:_____ Relationship:_____

Date of Birth:_____ Age:_____ SSN:_____

Street Address (If different than patient's):_____

City:_____ State:_____ Zip Code:_____

Primary Telephone:_____ Type:_____ Okay to leave message?:_____

Primary Email:_____

Employer:_____

Responsible Party Name:_____ Relationship:_____

Date of Birth:_____ Age:_____ SSN:_____

Street Address (If different than patient's):_____

City:_____ State:_____ Zip Code:_____

Primary Telephone:_____ Type:_____ Okay to leave message?:_____

Primary Email:_____

Employer:_____

Emergency Contact Information

Emergency Contact Name:_____ Relationship:_____

Primary Telephone:_____ Type:_____ Okay to leave message?:_____

Insurance Information

Primary Insurance Company:_____ Telephone:_____
Group #:_____ Policy #:_____ Member ID #:_____
Policy Holder's Name:_____ Relationship:_____
Policy Holder's SSN:_____ Policy Holder's Date of Birth:_____
Employer:_____ Work Telephone:_____
Co-Pay (If known):_____ Deductible (If known):_____
Secondary Insurance Company:_____ Telephone:_____
Group #:_____ Policy #:_____ Member ID #:_____
Policy Holder's Name:_____ Relationship:_____
Policy Holder's SSN:_____ Policy Holder's Date of Birth:_____
Employer:_____ Work Telephone:_____
Co-Pay (If known):_____ Deductible (If known):_____

Dental History

General or Pediatric Dentist Name:_____
Dentist Office Name:_____
Date of Last Visit:_____ Dental Work Planned?:_____
How did you hear about us? ____Dentist ____Internet ____Ad ____Friend ____Other
Name of person referring (If applicable):_____
Has patient visited an orthodontist before?_____
When?:_____ Reason?:_____
Have we treated other family members before?_____ Name:_____
Has patient's tonsils or adenoids been removed? ____Yes ____No
Does patient have known sleep-disordered breathing? ____Yes ____No
Does patient experience in jaw pain, locking, or discomfort? ____Yes ____No
If yes, please explain:_____
Has patient ever had an injury to the teeth or jaws? ____Yes ____No
Does patient have speech problems? ____Yes ____No
Does patient have any of the following habits? (check all that apply)
____Clenching/Grinding Teeth ____Mouth Breathing ____Thumb/Finger Sucking
____Lip Sucking/Biting ____Nail Biting ____Chewing Problem

Medical History

Is patient currently being treated by a physician? ____Yes ____No
If yes, reason?_____

Physician Name:_____ Last Visit:_____ Telephone:_____

Please list all prescription or over-the-counter medication:_____

_____

Please describe any major medical concerns:_____

Please describe any serious illnesses or operations:_____

Please describe any developmental concerns:_____

Has patient ever had a blood transfusion? ____Yes ____No

If yes, please give approximate dates:_____

Allergies/Sensitivities to medication or latex? ____Yes ____No

Is patient pregnant? ____Yes ____No

Does patient have or has ever had any of the following:

Anemia	____Yes	____No	Hepatitis	____Yes	____No
Arthritis, Rheumatism	____Yes	____No	High Blood Pressure	____Yes	____No
Artificial Heart Valves	____Yes	____No	HIV/AIDS	____Yes	____No
Artificial Joints	____Yes	____No	Jaw Pain	____Yes	____No
Asthma	____Yes	____No	Kidney Disease	____Yes	____No
Back Problems	____Yes	____No	Liver Disease	____Yes	____No
Blood Disease	____Yes	____No	Mitral Valve Prolapse	____Yes	____No
Cancer	____Yes	____No	Pacemaker	____Yes	____No
Chemical Dependency	____Yes	____No	Radiation Treatment	____Yes	____No
Chemotherpay	____Yes	____No	Respiratory Disease	____Yes	____No
Circulatory Problems	____Yes	____No	Rheumatic Fever	____Yes	____No
Cortisone Treatments	____Yes	____No	Scarlet Fever	____Yes	____No
Cough, Persistent	____Yes	____No	Shortness of Breath	____Yes	____No
Coughing Blood	____Yes	____No	Skin Rash	____Yes	____No
Diabetes	____Yes	____No	Stroke	____Yes	____No
Epileppsy	____Yes	____No	Swelling Feet/Ankles	____Yes	____No
Fainting	____Yes	____No	Thyroid Problems	____Yes	____No
Glaucoma	____Yes	____No	Tobacco Habit	____Yes	____No
Headaches	____Yes	____No	Tonsilitis	____Yes	____No
Heart Murmur	____Yes	____No	Tuberculosis	____Yes	____No
Heart Problems	____Yes	____No	Ulcer	____Yes	____No
Hemophelia	____Yes	____No	Venereal Disease	____Yes	____No

Authorization

- I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in the patient's medical status.
- I hereby authorize the release of any information pertaining to the patient's medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained

_____

Patient Signature or Responsible Party Date