Thank you for choosing Wilborn Orthodontics. Please complete this form in ink, front and back. Ask if you need assistance.

Wilborn orthodontics

Patient Information

(Please Print)

Name_____ Age_____ Gender_____
First Middle Last

Birthdate_____ SS#_____ DL#_____ Home Phone#_____

Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____

Employer Address_____ City_____ State_____ Zip_____ Work Phone_____

E-Mail_____ Cell#_____

Are you: ( )Minor ( )Single ( )Married ( )Divorced ( )Separated ( )Widowed

If patient is a student, name of school/college_____

Person to contact in case of an emergency_____ Phone #_____

Who may we thank for referring patient to us?_____

Name(s) of any family members we have treated_____

In your own words, what is patient's problem?_____

Dental History

Name of Dentist_____ Date of last exam_____

Please check any of the following conditions that apply to patient:

( )Bad Breath	( )Crowns	( )Jaw Pain	( )Sensitivity to Cold
( )Bleeding	( )Earaches	( )Loose Teeth	( )Sensitivity to Hot
( )Bridgework	( )False Teeth	( )Mouth Breather	( )Sensitivity to Sweets
( )Broken Fillings	( )Food Between Teeth	( )Neck Pain	( )Sensitivity when Biting
( )Clicking/Popping Jaws	( )Grinding Teeth	( )Partial Dentures	( )Sores/Growth in Mouth
( )Cleft Palate	( )Headaches	( )Periodontal Care	

Medical History

Name of Physician_____ Date of last visit_____

Please list all medications patient is currently taking:_____

_____

Allergies:_____

(Women) Is patient pregnant? ( )Yes ( )No / Nursing? ( )Yes ( )No / Taking Birth Control? ( )Yes ( )No

Does patient have a history of any of the following?

( )AIDS	( )Circulatory Problems	( )HIV Positive	( )Shortness of Breath
( )Anemia	( )Cough, Persistent	( )Kidney Disease	( )Skin Rash
( )Arthritis, Rheumatism	( )Cough Up Blood	( )Liver Disease	( )Stroke
( )Artificial Heart Valves	( )Diabetes	( )Major Surgery	( )Swelling of Feet
( )Artificial Joints	( )Epilepsy	( )Mitral valve Prolapse	( )Thyroid Problems
( )Asthma	( )Fainting	( )Nervous Problems	( )Tobacco Habit
( )Back problems	( )Glaucoma	( )Pacemaker	( )Tonsillitis
( )Blood Disease	( )Heart Murmur	( )Psychiatric Care	( )Tuberculosis
( )Blood Transfusion	( )Heart Problems	( )Radiation Treatment	( )Ulcer
( )Cancer	( )Hemophilia	( )Respiratory Disease	( )Venereal Disease
( )Chemical Dependency	( )Hepatitis	( )Rheumatic Fever	
( )Chemotherapy	( )High Blood Pressure	( )Scarlet Fever	

Describe heart problems_____

Does patient require premedication?_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to health of patient. I authorize the orthodontist to release any information including the diagnosis and the records of any treatment or examination rendered to patient during the period of such orthodontic care to third party payers and/or health practitioners. **I UNDERSTAND THAT DENTAL INSURANCE MAY PAY LESS THAN THE ACTUAL AMOUNT OWED FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENTS OF ALL SERVICES RENDERED ON MY OR PATIENT'S BEHALF.**

_____ _____

Signature of Patient (or Guardian of patient is a minor) Date

Parent Information (please complete if patient is a minor)

Father's name _____ DOB _____
Address _____
City _____ St _____ Zip _____
Home Phone _____ Work Phone _____
SS# _____ DL# _____
Employer _____
Occupation _____
Address _____
City _____ St _____ Zip _____
E-mail _____ Cell# _____

Mother's name _____ DOB _____
Address _____
City _____ St _____ Zip _____
Home Phone _____ Work Phone _____
SS# _____ DL# _____
Employer _____
Occupation _____
Address _____
City _____ St _____ Zip _____
E-mail _____ Cell# _____

RESPONSIBLE PARTY INFORMATION (If patient is a minor, give parent or legal guardian information.)
NOTE: We cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent.

Relationship to patient: _____
Name _____ Home Phone # _____
Address _____
SS# _____ Drivers License# _____ Birthdate _____
Employer _____ Occupation _____ Phone# _____
Address _____
E-mail _____ Cell# _____
Are you: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

CONSENT FOR DIAGNOSTIC RECORDS

I _____, do consent to Wilborn Orthodontics taking any necessary diagnostic records, consisting of x-rays, photographs, and dental impression, for _____ in order to diagnose and formulate an orthodontic treatment plan. I understand that Wilborn Orthodontics will assist in filing for any insurance benefits I am entitled to receive, but that **ultimately I, and not my insurance company, will be responsible for paying all charges associated with services performed.** I also waive now and forever my right of exemption from legal action under the constitution of the state of Alabama and all other states. I also agree to pay all costs, associated with the collection of any balance on the above patient's account, including but not limited to, late fees, collection costs, reasonable attorney fees, and court costs.
If divorce is involved, who is the custodial parent? _____
May patient information be released to the non-custodial parent? ( ) Yes ( ) No
Note: Payment is due in full the day diagnostic records are made.

_____ _____
Signature Date

DENTAL INSURANCE INFORMATION Name of Patient _____
NOTE: Insurance information must be completely filled out in order to file for your benefits.

Primary Insurance Co. _____ Address _____
Group# _____ Contract# _____ Phone# _____
Employer _____ Employment Date _____
Insured Name _____ Birthdate _____ SS# _____
Relationship to Patient _____ Lifetime Orthodontic Maximum $_____
I authorize the release of any information related to this claim.

Signature _____ Date _____

Secondary Insurance Co. _____ Address _____
Group# _____ Contract# _____ Phone# _____
Employer _____ Employment Date _____
Insured Name _____ Birthdate _____ SS# _____
Relationship to Patient _____ Lifetime Orthodontic Maximum $_____
I authorize the release of any information related to this claim.

Signature _____ Date _____