

Welcome to Village Orthodontics

Thank you for selecting our orthodontic team! We will strive to provide you with the best possible orthodontic care. If you have any questions or need assistance, please ask us - we will be happy to help.

THE FOLLOWING INFORMATION IS CONFIDENTIAL

PATIENT

Patient's Full Name: _____ Patient's Nickname/Preferred Name To Go By: _____

Patient's DOB(MM/DD/YY): _____ Patient's Age: _____ Patient's Sex: M F

Patient's Address: _____

City: _____ State: _____ Zipcode: _____ Patient's SSN: _____

Best Telephone Number to be reach patient at: _____

What type of number is this: CELL HOME WORK ext: _____ OTHER _____

Secondary Telephone Number to reach patient at: _____

What type of number is this: CELL HOME WORK ext: _____ OTHER _____

Who does the patient reside with: _____

Patient's School/Employer: _____ Patient's Email Address: _____

RESPONSIBLE PARTY

Patient's Responsible Party's Full Name: _____ Relationship to Patient: _____

Responsible Party's DOB (MM/DD/YY): _____ Responsible Party's Age: _____ Responsible Party's Sex: M F

Responsible Party's Address: _____

City: _____ State: _____ Zipcode: _____ Responsible Party's SSN: _____

Responsible Party's Email Address: _____

Best Telephone Number to be reach responsible party at: _____

What type of number is this: CELL HOME WORK ext: _____ OTHER _____

Secondary Telephone Number to reach responsible party at: _____

What type of number is this: CELL HOME WORK ext: _____ OTHER _____

Responsible Party's Marital Status: _____ Responsible Party's Spouse Name (first and last): _____

Responsible Party's Spouse Relationship to Patient: _____

Does the responsible party have any other children: YES NO If so, how many? _____

Children's ages/sex/names (first and last): _____

DENTAL INSURANCE

Is there any dental insurance we can check for you: YES NO Have we already received your insurance information: YES NO

If there is dental insurance and we have not received the information yet, please complete the following:

Insurance Company: _____ Insurance's Telephone Number: _____

Group Number: _____ Member ID: _____ The Insured's SSN: _____

Who is the insured (full name): _____ Relationship to Patient: _____

Insured's Employer: _____ Insured's Date of Birth (MM/DD/YY): _____

Is there any secondary dental insurance: YES NO Have we already received your secondary insurance information: YES NO

If there is secondary insurance and we have not received the information yet, please complete the following:

Insurance Company: _____ Insurance's Telephone Number: _____

Group Number: _____ Member ID: _____ The Insured's SSN: _____

Who is the insured (full name): _____ Relationship to Patient: _____

Insured's Employer: _____ Insured's Date of Birth (MM/DD/YY): _____

FINANCIAL ARRANGEMENTS

For your convenience we offer the following methods of payment. Please check the option you prefer:

Payment in full every month (whether you have an appointment or not).

We accept the following payment types: CASH, PERSONAL CHECK, VISA, MASTER CARD, AMERICAN EXPRESS, and DISCOVER.

Automatic monthly payment plan.

We charge your monthly orthodontic fee on your credit card (of your choice) each month on either the 1st or the 15th (the choice is yours) so you don't have to worry about coming in each month to make your payment. This assures you'll never fall behind on payments and that your account is paid off by the end of your treatment. Most patients prefer this option.

We accept the following credit cards: VISA, MASTER CARD, AMERICAN EXPRESS, and DISCOVER.

PHYSICIAN

Physician's Name: _____ Physician's Telephone Number: _____
Physician's Address: _____ City: _____ State: _____ Zip Code: _____
Date of your last check-up/physical (MM/DD/YY): _____ Check-up/physical Findings: _____

DENTIST

Dentist's Name: _____ Dentist's Telephone Number: _____
Dentist's Address: _____ City: _____ State: _____ Zip Code: _____
Date of last cleaning (MM/DD/YY): _____ Exam findings/any work needed: _____
Has the work needed been completed: YES NO If no, when is it scheduled to be completed (MM/DD/YY): _____

ORTHODONTIST

Has the patient been examined by another orthodontist before: YES NO IF SO, WHEN (MM/DD/YY): _____
Name of the orthodontist(s): _____
Have you experienced previous orthodontic treatment (including braces and/or other appliances)? YES NO
If so, start date (MM/DD/YY): _____ End Date (MM/DD/YY): _____
Please explain the type of orthodontic treatment (i.e. braces, invisalign, type of appliance, etc): _____

HABITS

SUCK THUMB/FINGER: YES NO CHEW HARD OBJECTS (PENCILS, ETC): YES NO
SUCK/BITE LIP: YES NO CLENCH JAWS: YES NO
BITE/CHEW NAILS: YES NO BRUXISM (TOOTH GRINDING): YES NO
MOUTH BREATHER: YES NO TONGUE THRUSTING: YES NO
ARE YOU A SMOKER: YES NO IF SO, HOW MANY PACKS A DAY: _____
ARE YOU AWARE OF ANY CLICKING/POPPING NOISE IN THE JAW JOINT: YES NO
How often do you brush your teeth: _____ How often do you floss your teeth: _____

APPEARANCE

Do you feel your teeth are too small or short? YES NO
Do you feel your teeth are too large or long? YES NO
Do you feel your teeth are crooked or crowded? YES NO
Do you feel your teeth are misshaped (uneven/pointed)? YES NO
Do you feel the upper front teeth are too far forward ("Buck Teeth/Over-Bite")? YES NO
Do you feel the upper front teeth are too far back ("Under Bite")? YES NO
Are there spaces between the teeth that you do not like? YES NO
Do you see too much or too little gum tissue when smiling? YES NO
Do you see any discoloration on your teeth? YES NO If so, please explain: _____
Are there other issues not listed above that you would like to have changed? YES NO If so, please explain: _____

MEDICAL HISTORY

ASTHMA: YES NO CANCER: YES NO
HANDICAPS/DISABILITES: YES NO TUBERCULOSIS: YES NO
HEPATITIS: YES NO DIABETES: YES NO
HIV/AIDS: YES NO HYPOGLYCEMIA: YES NO
PROSTHETIC VALVES/JOINT REPLACEMENTS: YES NO RHEUMATIC FEVER: YES NO
CONGENITAL HEART DEFECT: YES NO HEART MURMUR: YES NO
ABNORMAL BLEEDING/HEMOPHILIA: YES NO REMOVED TONSILS/ADENOIDS: YES NO
STOMACH, LIVER, OR KIDNEY PROBLEMS: YES NO CONVULSIONS/EPILEPSY: YES NO
Other : YES NO If so, please explain: _____
Do you have a history of allergies/sensitivities/adverse reactions to any of the following?
Latex: YES NO Novocain: YES NO Penicillin: YES NO
Other : YES NO If so, please explain: _____
Any previous hospitalizations/surgeries/serious illnesses: YES NO If so, when (MM/DD/YY): _____
Please explain: _____
Are you currently taking any medications: YES NO
If so, please list: _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to one's health. It is my responsibility to inform the orthodontic office of any changes in medical status and contact information. I also authorize the orthodontic office to perform the necessary orthodontic services needed. I also authorize the orthodontist to release any information including diagnosis and the records or treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay orthodontic benefits directly to your office. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered.

Printed Name of Patient or Responsible Party _____ Relationship to Patient _____
Signature of Patient or Responsible Party _____ Date _____
Signature of Orthodontist, Amanda R. Wilkinson, D.D.S., M.S. _____ Date _____