We are pleased to welcome you to KIZIOR & YOUNG ORTHODONTICS.
Before treatment can begin, we would like you to provide us, as completely and accurately as possible, the following information.
The information requested below is very important to our providing optimal care for you and it will be held in strictest confidence. Thank you.

Patient Name: _____ Preferred Name: _____ Gender: M F
Last *First* *Middle Initial*

Is Patient a Minor/under age 18 (please circle): Yes No Birth Date: ____/____/____ Age: _____ Is Patient Adopted: (please circle) Yes No

Home Phone:_____ Home Address_____ City_____ State_____ Zip _____

How would you like to receive appointment reminders: ☐ Cell Phone: _____ Cell Carrier: _____

☐ Email: _____

Name and Ages of Other Children in Family: _____

Other Family Members Seen by Us: _____ Whom May Thank for Referring You: _____

Is Patient is Employed? Employer: _____ Patient's Social Security #: _____

Father or Husband Information

Name: _____
Last *First* *Middle Initial*

Address: _____City/State/Zip:_____
(Complete only if different from patient's information)

Cell Phone: _____ Cell Carrier: _____

Email: _____

Birth Date:____/____/____ Social Security #: _____

Employer: _____ Employer Phone: _____

Mother or Wife Information

Name: _____
Last *First* *Middle Initial*

Address: _____City/State/Zip:_____
(Complete only if different from patient's information)

Cell Phone: _____ Cell Carrier: _____

Email: _____

Birth Date:____/____/____ Social Security #: _____

Employer: _____ Employer Phone: _____

BILLING INFORMATION

It is our goal to make financial arrangements as convenient as possible for all concerned. So that your account may be created in the correct fashion, please complete the following for us:

Person Financially Responsible for this Account: _____ Relationship to Patient: _____
(The account will be set up in this name)

Phone: _____ Address: _____ City/State/Zip: _____
(Complete only if different from patient's information)

INSURANCE INFORMATION

*As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us with **accurate and up-to-date** insurance information.*
*Please complete **ALL** lines and bring your **DENTAL** insurance card(s) with you at this appointment. A copy will be made for the patient's file.*

Primary Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth Date: ____/____/____ Social Security #: _____ Employer: _____

Insurance Company Name: _____ Orthodontic Coverage: (please circle) Yes No

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

Phone #: _____ Group #: _____ Member ID#: _____

Secondary Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth Date: ____/____/____ Social Security #: _____ Employer: _____

Insurance Company Name: _____ Orthodontic Coverage: (please circle) Yes No

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

Phone #: _____ Group #: _____ Member ID#: _____

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan, depending upon what you employer has agreed to with the insurer. Please keep in mind that insurance in not designed to provide 100% benefit, but rather is meant to assist in the cost of orthodontic care. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. You are personally responsible for your account, and encourage you to contact your insurance company if they have not paid within 30 days.

MEDICAL/DENTAL/ORTHODONTIC HISTORY

For the following questions, please circle yes or no and fill in any additional information.

Patient's Physician: _____ Physician's Address: _____ Phone: _____

Are you in good health? Yes No Are you being treated by any physicians at this time? Yes No

If yes, please list: _____

Are you currently taking any medication? If yes, please list:

Name: _____ How Long: _____ Why: _____

Name: _____ How Long: _____ Why: _____

Name: _____ How Long: _____ Why: _____

Please list any allergies or drug sensitivity

To what: _____ Age: _____ Reaction: _____

To what: _____ Age: _____ Reaction: _____

Females — Are you pregnant? Yes No

Do you have any history of the following conditions? Please check.

____ Rheumatic Fever
____ Emotional Difficulties
____ Diabetes
____ Birth Defects
____ Anemia
____ Hepatitis/Liver Disease
____ Fainting or Dizziness
____ Tuberculosis
____ High Blood Pressure
____ HIV/AIDS
____ Speech Difficulties
____ Heart Problems
____ Bleeding Problems
____ Asthma or Wheezing
____ Arthritis/Bone-Joint Problems
____ Hearing/Ear Problems
____ Heart Murmur
____ Kidney Disease
____ Epilepsy or Seizures

OTHER CONDITIONS: _____

____ THERE IS NO HISTORY OF ANY OF THE ABOVE PROBLEMS

Patient's Dentist: _____ Dentist's Address: _____ Phone: _____

Do you have jaw joint noises? Yes No Do you have jaw pain? Yes No Do you have bleeding gums? Yes No

Do you have sensitive teeth? Yes No Do you have headaches? Yes No

Do you have difficulty chewing your food or opening you mouth wide? Yes No

Have your teeth and/or mouth been injured in the past? Yes No

If yes, what was the cause of injury: _____

How old were you at the time?: _____ Which teeth and/or area of mouth were injured?: _____

Has the patient reached puberty? (Helps determine stage of growth) Yes No

Girls—At what age did she start menstruation? Age: _____ Not started yet: _____

Boys—At what age did puberty start? Age: _____

Has the patient had, or does he/she have any of the following habits? Please check.

____ Lip Biting/Sucking
____ Teeth Grinding/Clinching
____ Constant Mouth Breathing
____ Cheek or Nail Biting
____ Tongue Thrusting
____ Finger/Thumb/Blanket Sucking

____ THERE ARE NO ORAL HABITS

What is the reason for seeking orthodontic care?: _____

Does anyone else in the family have a similar orthodontic condition? Yes No Who?: _____

Has anyone else in the family received orthodontic care? Yes No

Who?: _____ Name of orthodontist?: _____

Has an orthodontist been consulted previously? Yes No

How well do you think the patient will react to orthodontic treatment?

_____ Excellent _____ Good _____ Fair _____ Poor _____ I don't know

Are there any other dental or medical conditions or symptoms that you feel we should know about? Yes No

If yes, please list: _____

_____

Additional Comments: _____

_____

Thank you for being so cooperative in answering the above questions. We look forward to providing the highest orthodontic care for the patient.

Adult Patient or Parent/Guardian Signature: _____ Relationship to Patient: _____ Date: ___/___/___