KIZIOR ORTHODONTICS PATIENT INFORMATION FORM.

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? **Yes** ☐ **No** ☐ Birth Date: _____/_____/_____ Age: _________ Is Patient Adopted? **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 We Thank for Referring You: ______________

If Patient is Employed - Employer: ____________________ Patient's Social Security #: ______________

Husband ☐ ***Father*** ☐ ***Step Father*** ☐ ***Guardian*** ☐

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: ____________

Wife ☐ ***Mother*** ☐ ***Step Mother*** ☐ ***Guardian*** ☐

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 and contract** may be created in the correct fashion, please complete the following for us:*

Person(s) Financially Responsible for this Account (The account will be set up in this name): ______________________________

Relationship to Patient: ______________ Person(s) Financially Responsible are: Married ☐ Separated ☐ Divorced ☐ Do Not Live Together ☐

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: **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: **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 your 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 CHECK Yes OR No and fill in any additional information.

Patient's Physician: ______________________________ Physician's Address: ______________________________

Are you being treated by any physicians at this time? **Yes** ☐ **No** ☐ If yes, please list why: ______________________________

Has the patient reached puberty? (Helps determine jaw growth) **Yes** ☐ **No** ☐ Females — Are you pregnant? **Yes** ☐ **No** ☐

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

Name: ____________________ How Long: ____________ Why: ____________________

Name: ____________________ How Long: ____________ Why: ____________________

Do you have any allergies Latex? **Yes** ☐ **No** ☐ Metals? **Yes** ☐ **No** ☐

Please list any other allergies or drug sensitivity To what: ____________________ Age: _____ Reaction: ____________

Do you have any history of the following conditions? Please check Yes OR No

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Rheumatic Fever	☐	☐	Hepatitis/Liver Disease	☐	☐	Speech Difficulties	☐	☐	Hearing/Ear Problems	☐	☐
Emotional Difficulties	☐	☐	Fainting or Dizziness	☐	☐	Heart Problems	☐	☐	Heart Murmur	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐	Bleeding Problems	☐	☐	Kidney Disease	☐	☐
Birth Defects	☐	☐	High Blood Pressure	☐	☐	Asthma or Wheezing	☐	☐	Epilepsy or Seizures	☐	☐
Anemia	☐	☐	HIV/AIDS	☐	☐	Arthritis/Bone-Joint Problems	☐	☐			

ANY OTHER MEDICAL CONDITIONS: ______________________________

Patient's Dentist: ______________________________ Dentist's Address: ______________________________

Do you have any of the following conditions: Jaw Joint Noises? **Yes** ☐ **No** ☐ Jaw Pain? **Yes** ☐ **No** ☐ Bleeding Gums? **Yes** ☐ **No** ☐

Difficulty Chewing or Opening Your Mouth Wide? **Yes** ☐ **No** ☐ Headaches? **Yes** ☐ **No** ☐ Sensitive Teeth? **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 had, or does he/she have any of the following habits? Please check Yes OR No

Habit	Yes	No	Habit	Yes	No	Habit	Yes	No
Lip Biting/Sucking	☐	☐	Constant Mouth Breathing	☐	☐	Tongue Thrusting	☐	☐
Teeth Grinding/Clenching	☐	☐	Cheek or Nail Biting	☐	☐	Finger/Thumb/Blanket Sucking	☐	☐

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 conditions or symptoms that you feel we should know about? **Yes** ☐ **No** ☐

If yes, please list: ______________________________

____

Additional Comments: ______________________________

May we use the patient's photo to be displayed on our Social Media sites (Facebook, Instagram, Website) as a means of congratulating them on starting treatment or showcasing their newly straightened smile after their braces are off? **Yes** ☐ **No** ☐

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 confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the orthodontic staff to perform any necessary orthodontic services that may be needed during diagnosis and treatment with my informed consent.
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:** ___/___/___