ADULT PATIENT INFORMATION ***PLEASE PRINT*** **Today's Date:_____**

(circle one): Mr. Mrs. Miss Ms. Dr. Rev. Prof.

Patient's Name:_____ SS#_____-___-_____ Sex____ DOB____/____/_____ Age_____

Address: _____ Apt#_____ City_____ State_____ Zip Code_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Email:_____

Employer's Name: _____ Your Work Phone (_____) _____-_____

Names of Family Members Treated Here: _____

Dental Provider: **DR**. _____ Address: _____ Phone (_____) _____-_____
(first & last name)

Who referred you to our office? _____ Are they our patient? (YES) or (NO)

How would you like to receive appointment reminders? Please choose 1

Phone call (_____) _____-_____ , Email _____ Text Message (_____) _____-_____, US MAIL

RESPONSIBLE PARTY BILLING INFORMATION

(Complete this section if an additional person will be financially responsible on your account)

(circle one): Mr. Mrs. Miss Ms. Dr. Rev. Prof.

Second Responsible Party Name: _____
Relationship to the patient: _____SS# _____-____-_____ DOB____/____/_____
Address: _____ Apt#_____ City_____ State_____ Zip Code_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Email:_____
Employer's Name: _____ Your Work Phone (_____) _____-_____

INSURANCE INFORMATION

Please provide us with your **CURRENT** orthodontic insurance information and we will be happy to assist you in filing your insurance claims. Please note that all payments are the responsibility of the patient, and an account will **NOT** be placed on hold awaiting benefits. In addition to this policy, our practice does NOT accept No-Fault insurance.

FINANCING OPTIONS

Our practice offers interest-free financing as well as free online pay for your orthodontic care. We accept all major credit cards and CARE CREDIT.

RECORDS RELEASE AUTHORIZATION

I consent to the examination and treatment by Dr. John Duthie and the staff of Duthie Orthodontics. I authorize DUTHIE ORTHODONTICS to release any and all of my diagnostic records, including but not limited to; records of office visits and treatment rendered, x-rays and photographs. Such records may be released to another dentist or orthodontist, or any other health care professional, for the purposes of discussing my condition, consulting on my case, or reviewing my dental records. These records may also be released to any governmental agencies, insurance companies, any managed care organizations which contract with my insurer for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered. This authorization shall remain in effect for fifteen years from the below said date.

Signature of First Responsible Party: _____ Today's Date: _____

Signature of Second Responsible Party: _____ Today's Date: _____
(if applies)

OFFICE USE ONLY

OFFICE WHERE PATIENT WILL BE TREATED:_____ ACCOUNT#_____ DATE UPDATED:_____ INITIALS: _____

PAT. NOTES:

CLASSIFICATION:_____**L**_____**R MIDLINES: MAX:**_____
MOLAR_____ **MAND:** _____
CANINE_____

CHIEF COMPLAINT: _____

_____

HABITS: _____ **TMJ:**_____

EXAM NOTES:_____

_____

_____

_____

OVERBITE:_____**%** **OVERJET:** _____**MM**

CROWDING: _____**UPPER/LOWER**_____

_____

RECORDS TAKEN: **TYPE:** **DATE:**

PATIENT NAME:_____**ACCOUNT #**_____

DR. D	M	F	P

ACTIVITIES/HOBBIES:_____

_____

CIRCLE ONE: INITIAL RECORDS/ RSR

TREATMENT TYPE	**X**	**RECORDS NEEDED**	**X**	**ADDITIONAL NOTES**	
PARTIAL TREATMENT		FULL RECORDS			
FULL TREATMENT		INDIRECT MODELS			
TRADITIONAL BRACES		DIAGNOSTIC MODELS			
CLEAR BRACKETS		SURGICAL MODELS			
INVISALIGN		PANOREX			
SEE DR. D ☺		CEPH			
		PHOTOS			
		HANDPLATE			

Patient Name _____ Record No. _____

Date of Birth ____/____/____

MEDICAL HISTORY

Physician _____
Address _____
Phone No. _____

1. When was your last physical exam? _____
2. Have there been any changes in your general health with the past year? _____
3. Is a physician for any reason treating you at present? _____
4. What medicine(s) are you taking now? _____
5. Have you ever been hospitalized for any illness, accident or surgery? _____
   If yes, when and why? _____
6. Woman: Are you pregnant now? _____

Do you have or have you had any of the following:

	Yes	No		Yes	No
7. Heart Trouble (including heart murmurs, valve, prosthesis/pacemaker)			26. Allergy, hay fever, hives		
8. Rheumatic fever			27. Asthma		
9. High/Low blood pressure			28. Sinus problems		
10. Kidney problems			Are you allergic to or have you had any unusual reactions to the following?		
11. Liver Disease (hepatitis)				Yes	No	Unknown
12. Jaundice			29. Penicillin			
13. Diabetes			30. Dental local			
14. Anemia, Sickle cell, Iron			31. Barbiturates			
15. Prolonged bleeding			32. Codeine or other narcotics			
16. Severe infections			33. Aspirin			
17. Epilepsy			34. Sedatives			
18. Fainting			35. Sulfa			
19. Convulsions			36. Specify other			
20. Pneumonia						
21. Tuberculosis						
22. Venereal Disease, AIDS, ARC			Do you have any other disease, condition emotional problems you would like to bring to our attention?			
23. Latex or vinyl (glove) allergy						
24. Metal Allergies (jewelry, etc.)						
25. Arthritis						

DO NOT WRITE BELOW THIS LINE

FOR DOCTOR'S USE ONLY

Summary of medical history/ medical problems affecting dental treatment:

_____

_____

HX obtained from _____ Reviewed by Dr. _____ Date ____/____/____

DENTAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:	YES	NO
Orthodontic (straightening of the teeth) As a child _____, or an adult _____.		
Extractions How long ago_____ Reason for extractions _____		
Periodontal treatment		
Mouthguard or splint (plastic device between your teeth)		
Treatment or surgery to change your bite		

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

Sores, lumps or irritated areas in your mouth		
Food catching or collecting between your teeth		
Clenching or grinding your teeth		
Clicking, popping or grating noise in your jaw when chewing Does it bother you? _____		
Numbness or tingling in your mouth or face		
Would you change anything about your teeth or smile?		

Over the past five years, how often have you been seen for teeth cleaning? _____

The date of your last visit to a dentist _____.

That dentist's name _____

DATE: _____PATIENT SIGNATURE _____