

**CHILD PATIENT INFORMATION**

(under the age of 18)

**PLEASE PRINT**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Patient's** Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

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)

**RESPONSIBLE PARTY BILLING INFORMATION**

**(Any orthodontic policy holder must be listed as a responsible party)**

**FIRST** Responsible Party Name: (Mr. Mrs. Miss Ms. Dr. Rev. Prof.) \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Your Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Phone call (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, Email \_\_\_\_\_ Text Message (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, US MAIL

**SECOND** Responsible Party Name: (Mr. Mrs. Miss Ms. Dr. Rev. Prof.) \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Your Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Phone call (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, Email \_\_\_\_\_ Text Message (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, US MAIL

**THIRD** Responsible Party Name: (Mr. Mrs. Miss Ms. Dr. Rev. Prof.) \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Your Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Phone call (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, Email \_\_\_\_\_ Text Message (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, US MAIL

**FOURTH** Responsible Party Name: (Mr. Mrs. Miss Ms. Dr. Rev. Prof.) \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Your Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Phone call (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, Email \_\_\_\_\_ Text Message (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_, US MAIL

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

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

**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 primary responsible party, 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 of \_\_\_\_\_ by Dr. John Duthie and the staff of Duthie Orthodontics. I authorize DUTHIE ORTHODONTICS to release any and all 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 the patients' condition, consulting on said case, or reviewing 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: \_\_\_\_\_