



**Kieffer Orthodontics**  
— A Team Approach —

**PATIENT INFORMATION**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

LAST FIRST MIDDLE INITIAL

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_ OTHER FAMILY MEMEBERS SEEN BY US \_\_\_\_\_

**RESPONSIBLE PARTY**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATION \_\_\_\_\_

LAST FIRST MIDDLE INITIAL

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**PRIMARY DENTAL INSURANCE - ORTHODONTIC COVERAGE?** Yes No

INSURANCE COMPANY NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

CLAIMS ADDRESS \_\_\_\_\_ INSURED'S EMPLOYER \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATION \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ INSURANCE GROUP/POLICY # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE - ORTHODONTIC COVERAGE?** Yes No

INSURANCE COMPANY NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

CLAIMS ADDRESS \_\_\_\_\_ INSURED'S EMPLOYER \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATION \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ INSURANCE GROUP/POLICY # \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I understand that my contract for orthodontic coverage is between the insurance carrier and myself. I am also aware that Kieffer Orthodontics will bill my insurance carrier as a courtesy and that the ultimate responsibility for charges on my account are mine. I understand that my payable insurance benefits will be reimbursed to me as the services are rendered in most cases.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

OVER →

**DENTAL INFORMATION**

Dentist's Name \_\_\_\_\_ Dentist's Phone # \_\_\_\_\_

What are the main reasons for your orthodontic evaluation? \_\_\_\_\_

Are you happy with your smile? If not, what would you like to change? \_\_\_\_\_

Have you been evaluated for orthodontic treatment in the past? If yes, explain: \_\_\_\_\_

Have you had difficulty related to previous dental work? If yes, explain: \_\_\_\_\_

Do you experience pain/discomfort in the jaw joint (TMJ)? If yes, explain: \_\_\_\_\_

Has there been any injury to your mouth, teeth or chin? If yes, explain: \_\_\_\_\_

Is your current dental health good, fair or poor? \_\_\_\_\_

Do you breathe through your mouth? If so, while sleeping or when awake? \_\_\_\_\_

Are you aware of any missing or extra permanent teeth? \_\_\_\_\_

Do you still have your wisdom teeth? \_\_\_\_\_

Do you have any speech problems? \_\_\_\_\_

**MEDICAL INFORMATION**

Physician's Name \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Are you under the care of a physician? If yes, explain: \_\_\_\_\_

Is your current medical health good, fair or poor? \_\_\_\_\_

Please list any serious medical conditions: \_\_\_\_\_

Please list any medications you are taking: \_\_\_\_\_

Please list any known allergies, including jewelry/metal & latex: \_\_\_\_\_

Check any of the following diseases or medical conditions that may apply:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Psychiatric Problems    |
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Alcohol/Drug Abuse      | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Shingles                |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Fainting Spells      | <input type="checkbox"/> Hospitalized          | <input type="checkbox"/> Sickle Cell Disease     |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Frequent Headaches   | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> Cancer/Chemotherapy     | <input type="checkbox"/> Heart Attack/Surgery | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis (TB)       |
| <input type="checkbox"/> Colitis                 | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Phen-Phen             |  |

**RELEASE**

I understand that the information that I have given today is correct to the best of my knowledge and that it will be held in the strictest of confidence. I understand that it is my responsibility to inform Kieffer Orthodontics of any changes in the patient's financial or medical/dental status. I authorize Kieffer Orthodontics to perform any necessary dental services needed during the patient's diagnosis and treatment. I understand that I am responsible for all charges incurred for services rendered, regardless of whether my insurance company reimburses me. I further agree that in the case of nonpayment, I am responsible for the cost of collection and/or legal fees should such action be required.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date