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_____

WHO IS ACCOMPANYING THE PATIENT TODAY? _____ RELATION _____

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

INSURANCE COMPANY NAME_____ PHONE NUMBER_____

CLAIMS ADDRESS_____ ORTHODONTIC COVERAGE? YES or NO

INSURED'S NAME_____ DATE OF BIRTH____/____/____ RELATION_____

INSURED'S EMPLOYER_____ INSURED'S SOCIAL SECURITY #_____

SUBSCRIBER ID_____ 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 concerns with your speech?_____

Do you have any sleep concerns? _____

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:

____Abnormal Bleeding	____Diabetes	____Hepatitis	____Rheumatic/Scarlet Fever
____AIDS	____Difficulty Breathing	____Herpes/Fever Blisters	____Seizures
____Alcohol/Drug Abuse	____Emphysema	____High Blood Pressure	____Shingles
____Anemia	____Epilepsy	____HIV	____Sickle Cell Disease
____Arthritis	____Fainting Spells	____Hospitalized	____Sinus Concerns
____Artificial Bones/Joints	____Frequent Headaches	____Kidney Concerns	____Sleep Apnea
____Asthma	____Glaucoma	____Liver Disease	____Stroke
____Blood Transfusion	____Hay Fever	____Low Blood Pressure	____Thyroid Concerns
____Cancer/Chemotherapy	____Heart Attack/Surgery	____Mental Health Concerns	____Tuberculosis (TB)
____Colitis	____Heart Murmur	____Mitral Valve Prolapse	____Ulcers
____Congenital Heart Defect	____Hemophilia	____Pacemaker	

RELEASE

The information I have provided on this form is correct to the best of my knowledge and I understand it will be held in the strictest of confidence. I understand 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 am aware that diagnostic imaging may be taken at the initial exam in order to render the best treatment plan, however, fees will apply for the imaging when taken and/or if the images are taken elsewhere. 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