SS __________ OM __________ Status __________ Pt.# __________

GREELEY & NISTA ORTHODONTICS, P.A.

PATIENT INFORMATION

Date of Appointment ____________________

Patient's Name ____________________

Address ____________________

City ____________________ State __________ Zip __________

Phone (home) __________ (work) __________ (cell) __________

Social Security # __________ Date of Birth __________ Age __________

If patient is a minor, School ____________________ Grade __________

Custodial Parent/Guardian ____________________

RESPONSIBLE PARTY / ADULT PATIENT INFORMATION

Name ____________________ Marital Status __________

Relationship to Patient ____________________ Date of Birth __________

Street Address ____________________

City ____________________ State __________ Zip __________

How long at this address __________ Social Security # __________

Phone (home) __________ (work) __________ (cell) __________

Employer __________ Occupation __________ Yrs. __________

Email address for appointment notification ____________________

Spouse Information

Name ____________________ Marital Status __________

Relationship to Patient ____________________ Date of Birth __________

Employer __________ Occupation __________ Yrs. __________

Work Phone __________ Social Security # __________

DENTAL INSURANCE INFORMATION

Primary Dental

Name of Insured ____________________

Insured Date of Birth ____________________

Insured Zip Code ____________________

Social Security# ____________________

Relation to Insured ____________________

Employer ____________________

Insurance Carrier ____________________

Group# ____________________

Carrier Phone # ____________________

Secondary Dental

Name of Insured ____________________

Insured Date of Birth ____________________

Insured Zip Code ____________________

Social Security# ____________________

Relation to Insured ____________________

Employer ____________________

Insurance Carrier ____________________

Group# ____________________

Carrier Phone# ____________________

Patient Acknowledgement and Authorization

I hereby acknowledge the above information to be accurate and complete. I give permission to Greeley & Nista Orthodontics, PA to perform an examination and diagnostic records, including photographs, digital x-rays, and impressions, for the sole purpose of determining treatment.

____

Signature (Parent/Guardian if minor) Date

Insurance Authorization and Assignment of Benefits

I authorize release of any information relating to the orthodontic claim. I hereby authorize payment directly to Greeley & Nista Orthodontics, PA of any insurance benefits.

____

Signature (Parent/Guardian if minor) Date

Turn form over to complete other side →

MEDICAL HISTORY

Physician ____________________

Date of last medical examination ____________________

General Health: ☐ Good ☐ Fair ☐ Poor

Medication ____________________

Allergies (to environment or medicines) ____________________

Has the patient ever had or been treated for:

☐ asthma	☐ diabetes	☐ high blood pressure	☐ pneumonia
☐ arthritis	☐ digestion problems	☐ HIV+	☐ rheumatic fever
☐ AIDS	☐ diphtheria	☐ influenza	☐ frequent sore throat
☐ blood disorder	☐ drug addiction	☐ heart problem	☐ strep. Infection
☐ bronchitis	☐ ear infections	☐ kidney problem	☐ tonsillitis
☐ cancer	☐ epilepsy	☐ liver problem	☐ tuberculosis
☐ chicken pox	☐ frequent headaches	☐ measles	☐ venereal disease
☐ frequent colds	☐ hearing problems	☐ mononucleosis	☐ vision problem
☐ dermatitis	☐ herpes		

Has the patient ever had: **(state when)**

Tonsils and /or adenoids removed ____________________

Ear tubes placed ____________________

Broken hand, arm, leg, etc. ____________________

Appendectomy ____________________

Major surgery ____________________

DENTAL HISTORY

Dentist ____________________

Date of last dental examination ____________________

Does the patient have:

☐ Bleeding gums

☐ Poor hygiene habits

☐ Poor eating habits

Habits:

☐ Nail biting

☐ Night grinding

☐ Thumbsucking

☐ Mouth breathing

Other ____________________

IF PATIENT IS A CHILD

Does the patient play a musical instrument by mouth? ____________________

Height: Father __________ Mother __________ Patient __________

Female patient: Age of onset of monthly menstrual period ____________________

Please inform us of any change in health condition or medication.

Referred by ____________________

Chief orthodontic concern: ____________________

Previous orthodontic experience: ____________________

Special Notes: ____________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____________________

Address ____________________

City ____________ State ____________ Zip ____________

Phone ____________ Relationship ____________

UPDATES (Date & Initial) ____________________