GREELEY & NISTA ORTHODONTICS, P.A.
www.firststatesmiles.com

PT#_____Status_____

Patient's Name _____Title _____

Prefers to be called _____Date of Birth_____Age_____Sex _____

Address _____City, State, Zip _____

How long at this address _____Social Security # _____

Phone (home) _____(cell) _____(work) _____Email _____

If Patient is minor, who does patient live with _____

If Patient is adult, Employer _____Yrs _____Occupation_____

Referred by _____

RESPONSIBLE PARTY (IF MINOR)

Name _____Title _____Relationship to Patient _____

Address *(if different)* _____City, State, Zip _____

How long at this address _____Social Security # _____Date of Birth _____

Phone (home) _____(cell) _____(work) _____Email _____

Employer _____Yrs _____Occupation_____

2ND RESPONSIBLE PARTY (IF MINOR)

Name _____Title _____Relationship to Patient _____

Address *(if different)* _____City, State, Zip _____

How long at this address _____Social Security # _____Date of Birth _____

Phone (home) _____(cell) _____(work) _____Email _____

Employer _____Yrs _____Occupation_____

DENTAL INSURANCE INFORMATION

PRIMARY

Name of Insured _____Relationship to Patient_____

Address *(if different)* _____City, State, Zip _____

Phone *(if different)*_____Insured's Date of Birth_____ Social Security # or Dental ID# _____

Employer _____Ins. Carrier_____

Group#_____Carrier Phone # _____

SECONDARY

Name of Insured _____Relationship to Patient_____

Address *(if different)* _____City, State, Zip _____

Phone *(if different)*_____Insured's Date of Birth_____ Social Security # or Dental ID# _____

Employer _____Ins. Carrier_____

Group#_____Carrier Phone # _____

Turn over to complete other side →

MEDICAL HISTORY

Physician _____Date of last examination _____General Health_____

Medications Taken _____

Allergies (medicines/environmental) _____

Has patient ever had or been treated for:

☐ asthma	☐ chicken pox	☐ drug addiction	☐ HIV+	☐ measles	☐ strep infection
☐ arthritis	☐ freq. colds/sore throat	☐ ear infections	☐ influenza	☐ mental health issues	☐ tonsillitis
☐ AIDS	☐ dermatitis	☐ epilepsy	☐ heart problems/murmur	☐ mononucleosis	☐ thyroid problem
☐ blood disorder	☐ diabetes	☐ freq. headaches	☐ kidney problems	☐ pneumonia	☐ tuberculosis
☐ bronchitis	☐ digestion problem	☐ hearing problems	☐ learning disabilities	☐ rheumatic fever	☐ venereal disease
☐ cancer	☐ diphtheria	☐ high/low blood pressure	☐ liver problem	☐ sensory issues	☐ vision problems

Has the patient ever had surgery (type and when) _____

Does patient take antibiotic pre-medication before dental appointments? _____

DENTAL HISTORY

Dentist _____Date of last examination_____

Does patient have: ☐ Abnormal swallowing ☐ Bleeding gums ☐ Poor hygiene habits ☐ Snoring ☐ Mouth Breathing

Patient habits: ☐ Nail biting ☐ Night grinding ☐ Thumb/finger sucking ☐ Other_____

Does the patient play a musical instrument by mouth? _____

IF MINOR: Height: Father_____Mother _____Patient _____ Female: Age of onset of menstrual period _____

Chief Orthodontic Concern: _____Previous orthodontic experience _____

NOTES: _____

_____

EMERGENCY INFORMATION

Name of nearest relative: _____Phone # _____

Address *(if different than above)* _____

Patient Acknowledgement and Authorization:

I hereby acknowledge the above information to be accurate and complete. I give permission for Greeley & Nista Orthodontics, PA to perform an exam and take diagnostic records, including photographs and x-rays for the purpose of determining treatment. I will notify Greeley and Nista Orthodontics, PA of any change in patient's health.

_____

Signature *(Parent/Guardian if minor)* Date

Insurance Authorization and Assignment of Benefits:

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

_____

Signature *(Parent/Guardian if minor)* Date