

NEW PATIENT INFORMATION

Today's Date _____ Male Female

Patient's Name _____ Birth Date _____ Age _____
 Last First

Address _____
 Street City State Zip

Home Phone (____) _____ Patient Cell Phone (____) _____ Patient SS# _____

What school do you attend? _____ Whom may we thank for referring you to our office? _____

For appointment reminders – PATIENT's email: _____ @ _____

If patient is a minor, give parent's or guardian's name _____

IF ADULT - PATIENT INFORMATION or PARENT/RESPONSIBLE PARTY INFORMATION

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a minor's orthodontics. The parent/legal guardian accompanying the minor will be the responsibility party.

May patient information be released to a non-custodial parent? YES NO

Name _____
 Last First Middle Marital Status

Residence _____
 Street City State Zip How long @ address?

For Appointment Reminders & Account Information-Responsible Party Email _____ @ _____

Home phone (____) _____ Cell phone (____) _____ Work phone(____) _____ X- _____

SS# _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

SPOUSE/PARTNER'S Name _____ Home phone (____) _____

Residence _____
 Street City State Zip How long @ address?

For Appointment Reminders - Email _____ @ _____ Work Phone (____) _____

SS# _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

DENTAL INSURANCE INFORMATION – NOT MEDICAL

Subscriber's Name _____ Subscriber's Birth Date _____

Subscriber's Employer _____ Subscriber's SS# _____ Subscriber's ID No. _____

Insurance Company _____ Insurance Phone # _____

Insurance Co. Address _____ Group No. _____

Do you have dual coverage? (SECONDARY INSURANCE) NO YES If so:

Subscriber's Name _____ Subscriber's Birth Date _____

Subscriber's Employer _____ Subscriber's SS# _____ Subscriber's ID No. _____

Insurance Company _____ Insurance Phone # _____

Insurance Co. Address _____ Group No. _____

I authorize payment directly to Dr. Trimmell for any insurance benefits otherwise payable to me.
I certify that the information on this form is complete and true to the best of my knowledge.

****Signature (Parent's signature if minor)** _____

Patient Medical History

Does patient have a speech problem and if so, receiving speech therapy? NO YES
 Has patient had their tonsils or adenoids removed? NO YES
 Is patient presently under the care of a physician or taking medication? NO YES Patient's Physician: Dr. _____
 If so, What? _____
 Has patient ever had an unusual reaction to any drug? NO YES If so, what? _____
 Does patient require medication prior to any dental procedure? NO YES If so, why? _____
 Has patient had any of the following?
 [1] Arthritis [10] Diabetes [19] Major surgery [26] Osteoporosis
 [2] Anemia [11] Frequent colds [20] Tuberculosis [27] Taking Bisphosphonates?
 [3] Bleeding problem [12] Asthma [21] Heart trouble
 [4] Epilepsy/Seizures [13] Rheumatic Fever [22] Thyroid or Hormonal imbalance
 [5] Nervous disorder [14] Immune Deficiency [23] Any other serious medical problems
 [6] Hyperactivity [15] Ulcers [24] Have you ever had a concussion? NO YES
 [7] Hepatitis [16] Herpes/Oral-facial [25] Are you active in sports? NO YES
 [8] Venereal disease [17] Allergies/Sinus If so, what sports? _____
 [9] LATEX ALLERGY [18] METAL/NICKEL ALLERGY

Patient Dental History

Patient's General Dentist: Dr. _____
 Does the patient presently suck their thumb or fingers? NO YES
 Does the patient breathe mostly through the mouth? NO YES
 Does the patient snore often? NO YES
 Has the patient ever received a severe blow resulting in injury to the teeth or jaws? NO YES
 If yes, please write in details _____
 Does the patient grind their teeth at night? NO YES
 In the past, has the patient ever complained of (please circle) clicking popping stiffness soreness in the jaw or muscles?
 Episodes when the jaw would not open or close normally? NO YES
 Pain or discomfort in the front of the ear? NO YES
 Headaches, neck and or back pain? NO YES
 If yes, please write date and details: _____
 Has patient ever had orthodontic treatment or worn a retainer before? NO YES
 Would patient object to wearing orthodontic appliances should they be indicated? NO YES

What is patient's or parent's primary concern? _____

Emergency Information

Name of nearest relative NOT living with you _____
 Relationship _____ Phone (____) _____

HIPPA CONSENT SIGNED OFFICE USE ONLY

Date: _____ Patient Name: _____ Adult Present _____
 Records: Pano _____ Ceph _____ Pics _____ Model# _____

Comments: _____

Diagnosis: Buccal x-bite Anterior x-bite
 Class _____ OJ _____ OB _____ X-Bite _____
 Upper spacing _____ mm Lower spacing _____ mm
 Upper crowding _____ mm Lower crowding _____ mm

Midline R | | | | | L Missing teeth | | Impacted | | Extractions | |

LTR: Expose & Bo: _____ Surgery: _____

Notes: _____

Tx Plan: Recall Limited Tx-Up/Lo ULA/LLA Ph 1 Full Tx Full Tx w/surgery Invisalign Red/White/Blue

1ST Insurance Benefit: _____ pd @ _____ % 2ND Insurance Benefit: _____ pd @ _____ %

Est Tx Time _____ mos Dis: _____ ICFD _____ FAM _____ PRO _____ COUR _____ PIF

Payment Plan: _____

[] - (1st INS _____) - (2nd INS _____) = _____ - (dis _____) = _____ - (! _____) = _____ + _____ mos = _____