Ted Vossers, DDS, MS, PA

Orthodontic Patient Information

Date ___/___/___ -Please Print- Date of Birth____/____/____
Update___/___/___

Patient Name _____Sex _____SS# _____

Home Address _____Preferred Name_____

_____Home Phone_____

Email Address _____Cell Phone_____

Best Daytime Contact_____

Occupation/School _____Employer/Grade _____WorkPhone_____

Emergency Contact _____Relationship _____Phone _____

Hobbies/ Interests_____

Whom may we thank for recommending our office to you?_____

Physician _____Family Dentist _____Last Dental Visit_____

Please list any family members treated here _____

Person responsible for payment of the account _____Relationship_____

SS#_____D.O.B._____

Orthodontic Insurance? _____Company Name _____

Martial Status (circle one): Single Married Separated Divorced Widowed Other_____

If applicable: Spouse's Name _____SS#_____

Occupation _____Employer _____Business Phone _____

Names & ages of children _____

MEDICAL HISTORY

Yes No Any major or unusual illnesses?
Explain_____
Yes No Currently under physician's care?
Reason_____
Yes No Have taken or are taking Bisphosphonates(ex: Fosomax)?
How long ago?_____
Yes No Currently taking medication?
List_____
Yes No Any drug allergies/sensitivities?
List_____

Yes No PreMed-Dental Work	Yes No Osteoporosis	Yes No Joint Replacement
Yes No Heart Murmur	Yes No Hepatitis/Liver Disease	Yes No Speech/ Hearing Problems
Yes No Rheumatic Fever	Yes No Heart Trouble	Yes No Allergies
Yes No Epilepsy	Yes No High Blood Pressure	Yes No Diabetes
Yes No Fainting/Dizziness	Yes No Cold Sores/ Herpes	Yes No Frequent Colds/Flu
Yes No Asthma	Yes No AIDS Antibody Positive	Yes No Tonsilitis/ Adenitis
Yes No Glaucoma	Yes No Abnormal Bleeding	Yes No Tonsils/ Adenoids Removed
Yes No Contact Lenses	Yes No Frequent Headaches	Yes No Tuberculosis

DENTAL HISTORY

Yes No Any injuries to the face, mouth, or teeth?
Explain_____
Yes No Has the patient ever sucked a thumb or finger? Until what age?_____
Yes No Any history of jaw joint soreness, clicking, or popping?_____
Yes No Any history of clenching or grinding of teeth?_____
Yes No Has an orthodontist been consulted previously?
When?_____
Yes No Has the patient had any previous orthodontic treatment?
When?_____
Why are you seeking orthodontic consultation? (What is your main concern?)_____
_____

Any additional information which you feel would help make your association with us more enjoyable.

_____
_____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper orthodontic care.

I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) orthodontic care, advice and treatment to my dentist and/or referred specialist.

I hereby authorize payment of insurance benefits directly to Ted Vossers, DDS, MS, PA otherwise payable to me.

I understand that my orthodontic care insurance carrier or payor of my orthodontic benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

I authorize your office and/or a collection agency to contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the business providing service may contact me/us as described above.

I/We understand that there is a $25.00 fee if a check is returned form the bank.

Patient's or Guardian's
Signature_____Date_____

Witness Signature_____Date_____