WELCOME

PERSONAL INFORMATION

Date_____ Kling Orthodontics, Inc. Page 1

Name_____ I prefer to be called_____

Birthdate_____ Social Security#_____

Email address_____

Single _____ Married_____ Divorced_____ Widowed_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Email Address_____

Spouse's Name_____ Employer_____ Work Phone_____

Whom may we thank for referring you?_____

Name of nearest relative not living with you_____ Relationship_____

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

DENTAL HISTORY

Patient's Dentist_____ Phone_____ Date of Last Visit_____

Y **N** Do you require antibiotic therapy before dental treatment due to a heart condition?
Y **N** Have you ever had any accidents that require dental care?
Y **N** Have you ever had any pain or tenderness in your jaw joint (TMJ / TMD)?
Y **N** Have you ever been treated for periodontal disease?
Y **N** Have you ever had root canal therapy?
Y **N** Are you currently in pain?

What are your primary concerns?_____

_____

_____

Patient's Name_____ Kling Orthodontics, Inc. Page 2

Patient's Physician_____ Phone_____

List all medications you are currently taking_____

List any serious medical conditions (past or present)_____

_____

List all substances that cause you allergic reactions_____

MEDICAL HISTORY

Have you ever experienced any of the following:

Y	**N**	**Abnormal Bleeding**	**Y**	**N**	**Handicaps / Disabilities**	**Y**	**N**	**Mononucleosis**
Y	**N**	**ADHD / ADD**	**Y**	**N**	**Headaches**	**Y**	**N**	**Prosthetic Devices**
Y	**N**	**AIDS / HIV Positive**	**Y**	**N**	**Hearing Impairment**	**Y**	**N**	**Rheumatic Fever**
Y	**N**	**Allergies**	**Y**	**N**	**Heart Disease**	**Y**	**N**	**Scarlet Fever**
Y	**N**	**Anemia**	**Y**	**N**	**Heart Murmur**	**Y**	**N**	**Sickle Cell Anemia**
Y	**N**	**Arthritis**	**Y**	**N**	**Hemophilia**	**Y**	**N**	**Sinus Problems**
Y	**N**	**Asthma**	**Y**	**N**	**Hepatitis**	**Y**	**N**	**Skin Rashes/ Hives**
Y	**N**	**Blood Transfusions**	**Y**	**N**	**High or Low Blood Pressure**	**Y**	**N**	**Thyroid Condition**
Y	**N**	**Bone Fractures**	**Y**	**N**	**Hospitalizations**	**Y**	**N**	**Tonsillitis**
Y	**N**	**Cancer**	**Y**	**N**	**Kidney Problems**	**Y**	**N**	**Tuberculosis**
Y	**N**	**Chicken Pox**	**Y**	**N**	**Liver Problems**			
Y	**N**	**Congenital Heart Defect**	**Y**	**N**	**Lupus**			
Y	**N**	**Diabetes**	**Y**	**N**	**Major Accidents**			
Y	**N**	**Epilepsy**	**Y**	**N**	**Measles**			
Y	**N**	**Fainting Spells**	**Y**	**N**	**Mitral Valve Prolapse**			

Patient's Signature_____ Date_____ Doctor_____

Patient's Signature_____ Date_____ Doctor_____

ORTHODONTIC INSURANCE INFORMATION

PRIMARY

Insurance Company_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Insured's Name_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Group #_____

ID#_____ Insured's Employer_____

Employer Street Address_____ City_____ State_____ Zip_____

SECONDARY

Insurance Company_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Insured's Name_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Group #_____

ID#_____ Insured's Employer_____

Employer Street Address_____ City_____ State_____ Zip_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the above named patient(s) medical status. I authorize the dental staff to perform the necessary dental services the above named patient may need.

Signature_____ Date_____

I agree to be responsible for all charges for dental services and materials not a benefit of my dental plan. I authorize the release of any information relating to the dental benefit claim, and authorize payment of the dental benefit otherwise payable to me directly to Kling Orthodontics, Inc.

Signature_____ Date_____