JOHN T. KALANGE, DDS, MS

Orthodontics For Children, Adolescents & Adults

WELCOME TO OUR OFFICE....

PATIENT INFORMATION TODAY'S DATE _____

NAME (LAST)_____ (FIRST)_____ (MIDDLE)_____

NICKNAME_____ BIRTHDATE _____ AGE_____ SEX_____

ADDRESS (STREET)_____

(CITY)_____ (STATE)_____ (ZIP)_____ E-MAIL_____

PHONE (HOME)_____ (WORK)_____ (CELL)_____

IF MINOR, PARENTS'/GUARDIANS' (FIRST & LAST NAMES) (Mother) _____ (Father)_____

IF MINOR, NAME AND AGES OF BROTHER(S) AND SISTER(S): _____

IF STUDENT, NAME OF SCHOOL _____ PATIENT'S HOBBIES/INTERESTS _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

PATIENT'S DENTIST _____ PATIENT'S PHYSICIAN _____

RESPONSIBLE PARTY

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT COMPLETE THE FOLLOWING:

NAME OF RESPONSIBLE PARTY _____

ADDRESS _____

RESPONSIBLE PARTY SOCIAL SECURITY # _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ PHONE _____

WORK ADDRESS _____ SIGNATURE _____

INSURANCE *IF YOU HAVE NO INSURANCE, CHECK HERE* ❑

NAME OF INSURANCE COMPANY _____ PHONE _____

INSURANCE COMPANY ADDRESS _____

NAME OF INSURED PERSON _____ EMPLOYER _____

RELATIONSHIP OF INSURED TO PATIENT _____

GROUP # _____ POLICY# _____ SOCIAL SECURITY # _____

BIRTHDATE _____

IF THERE IS DUAL INSURANCE COVERAGE, PLEASE COMPLETE THE INFORMATION BELOW:

NAME OF INSURANCE COMPANY _____ PHONE _____

INSURANCE COMPANY ADDRESS _____

NAME OF INSURED PERSON _____ EMPLOYER _____

RELATIONSHIP OF INSURED TO PATIENT _____

GROUP # _____ POLICY# _____ SOCIAL SECURITY # _____

BIRTHDATE _____

I authorize release of all orthodontic/dental information necessary to process my insurance claims as is pertinent to my orthodontic care. I assign all orthodontic/dental benefits to which I am entitled to the above-named provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

RESPONSIBLE PARTY _____ DATE _____

OVER

The following is essential for this office to provide orthodontic care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet our orthodontic needs safely and efficiently. Incorrect information can be dangerous to your health. If you answer yes to any questions please give explanation.

CIRCLE ONE

How would you describe patient's general health? ..... Good Fair Poor

Has patient been under the care of a medical doctor during the past two years? ..... Yes No

If yes, who and for what reason? _____

_____

Has patient taken any medication or drugs during the past two years? ..... Yes No

Does patient take any medications on a daily basis? ..... Yes No

If yes, what medication and for what purpose(s)? _____

_____

Does patient have any allergies? ..... Yes No

If yes, please list all allergies. _____

_____

Has patient ever had excessive bleeding requiring special treatment? ..... Yes No

Does patient have any disease, condition or problem not listed? ..... Yes No

DOES PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? CIRCLE YES OR NO FOR EACH LISTED ITEM

Diabetes	Yes	No	Frequent Neckaches	Yes	No	Heart Trouble	Yes	No
AIDS	Yes	No	Abnormal Blood Pressure	Yes	No	Rheumatic Fever	Yes	No
H.I.V.+	Yes	No	Prolonged Bleeding	Yes	No	Venereal Disease	Yes	No
Seizures	Yes	No	Fainting or Dizziness	Yes	No	Tuberculosis	Yes	No
Anemia	Yes	No	Clenching or Grinding Teeth	Yes	No	Hay Fever	Yes	No
Epilepsy	Yes	No	Frequent Headaches	Yes	No	Nervous Disorders	Yes	No
Glaucoma	Yes	No	Soreness of Jaw Muscles	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Clicking/Locking Jaw Joints	Yes	No	Contact Lenses	Yes	No

Is patient pregnant? ..... Yes No

Have there been any injuries to the face, mouth, or teeth? ..... Yes No

Explain _____

Does patient have any speech problems? ..... Yes No

Is there past history of a car accident, or whiplash injury? ..... Yes No

Explain _____

Does patient use chewing gum on a regular basis? ..... Yes No

Did patient suck fingers or thumb? ..... Yes No

When did it stop? _____

Does patient suck fingers or thumb now? ..... Yes No

Does patient breathe through mouth more than nose? ..... Yes No

Has patient been seen or treated for orthodontics before? ..... Yes No

Has patient had chronic tonsillitis? ..... Yes No

Were tonsils and/or adenoids removed? ..... Yes No

When? _____

Does patient have any condition which requires pre-medication with antibiotics before dental treatment? ..... Yes No

PLEASE NOTE ANY MEDICAL OR HEALTH HISTORY THAT YOU FEEL IS IMPORTANT FOR US TO KNOW.

_____

_____

NOTE: ANY CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO OUR OFFICE IMMEDIATELY.

To the best of my knowledge, the above questions have been answered correctly.

Person completing the form: Signature _____

Print Name _____

If other than patient indicate relationship _____ Date _____

Office Use: I have reviewed medical history and confirm information is current and correct.

_____ _____

DATE SIGNATURE DATE SIGNATURE

_____ _____

DATE SIGNATURE DATE SIGNATURE