

Welcome to Dr. Ricupito's Orthodontic Practice

Please complete the following Biographical, Financial and Health History Forms.

Patient Name: _____ **E-Mail Address:** _____

Nickname: _____ Gender: M F Birthdate: ___/___/___ SS# _____

Responsible party: (if other than patient) _____

Home Address: _____

Mailing Address: _____

Home Phone: _____ Alternate Phone: _____ Cell Phone: _____

Other family members seen by us: _____ Referral Source: _____

General Dentist: _____ Last Visit: _____

Financial Responsibility Information: Please indicate the primary person for account responsibility.

Name: _____ **E-Mail Address:** _____

Employer: _____ Work Phone: _____ Date of Birth: ___/___/___ *SS# _____

Insurance Company Name: _____ ID# _____ Group # _____

Relationship to patient: _____

*Social Security number required for payment plan.

Primary I understand that I am responsible for payment of all services rendered including late fee's and missed appointment fee's should they apply and also responsible for paying any co-payment, deductibles or balances my insurance does not cover. This office reserves the right to verify credit status of potential patients and/or parents/guardians of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature: _____ **Date:** _____

Name: _____ **E-Mail Address:** _____

Employer: _____ Work Phone: _____ Date of Birth: ___/___/___ *SS# _____

Insurance Company Name: _____ ID# _____ Group # _____

Relationship to patient: _____

*Social Security number required for payment plan.

Primary I understand that I am responsible for payment of all services rendered including late fee's and missed appointment fee's should they apply and also responsible for paying any co-payment, deductibles or balances my insurance does not cover. This office reserves the right to verify credit status of potential patients and/or parents/guardians of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature: _____ **Date:** _____

Emergency Contact: (A person that does not live with you)

Name: _____ **Phone:** _____

DOES THE PATIENT SNORE WHEN SLEEPING?

- Yes No
- Sometimes: _____

DIFFICULTY CHEWING?

- Yes
 - Teeth don't meet well
 - Pain when chewing
 - Other: _____
- No

CHECK ALL THAT APPLY:

- Frequent sore throat/tonsillitis
- Speech problems
- Pain in the RIGHT jaw joint
- Pain in the LEFT jaw joint
- Clicking/popping in RIGHT jaw joint
- Clicking/popping in LEFT jaw joint
- Current thumb/finger sucking habit
- Previous thumb/finger sucking habit
- Lip biting/sucking habit
- Grind teeth
- Clench jaws
- Tongue thrust when swallowing

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?

- Yes: _____
- No

FREQUENCY OF DENTAL CHECKUPS?

- Once per year
- Twice per year
- More than twice a year
- Emergencies only
- Never

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

- Wants treatment
- Only if necessary
- Unwilling
 - But will cooperate if treatment is needed
- Uncooperative

ORTHODONTIC EXAM PROMPTED BY:

- Patient Mother Spouse
- Dentist Father Sibling
- Doctor Friend Other

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

- Yes, please describe: _____
- _____
- _____
- _____
- _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services that may be needed during diagnosis and treatment with my informed consent.

Responsible Party Signature

Printed Name

Date

DOCTOR'S NOTES:
