kozakorthodontics
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PATIENT INFORMATION

E-MAIL: _____

PATIENT'S NAME _____ SEX: ◇M ◇F
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE ( ) _____ BIRTHDATE _____ SOCIAL SECURITY # _____

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME _____

SCHOOL _____ MUSICAL INSTRUMENT PLAYED _____

HOBBIES AND SPORTS _____

SIBLINGS: NAME _____ AGE _____ NAME _____ AGE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

NAME _____ MARITAL STATUS _____
LAST FIRST MIDDLE

RESIDENCE _____
STREET CITY STATE ZIP

MAILING ADDRESS _____
STREET CITY STATE ZIP

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

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SOCIAL SECURITY # _____ BIRTHDATE _____ WORK / CELL PHONE ( ) _____

INSURANCE INFORMATION

INSURED'S NAME _____ SOCIAL SECURITY # _____
LAST FIRST MIDDLE

EMPLOYER'S NAME _____

INSURANCE COMPANY _____ GROUP # _____ ID # _____

INSURANCE COMPANY ADDRESS _____
STREET CITY STATE ZIP

DO YOU HAVE DUAL COVERAGE? _____ IF YES _____

INSURED'S NAME _____ SOCIAL SECURITY # _____
LAST FIRST MIDDLE

EMPLOYER'S NAME _____

INSURANCE COMPANY _____ GROUP # _____ ID # _____

INSURANCE COMPANY ADDRESS _____
STREET CITY STATE ZIP

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH THE PATIENT _____

COMPLETE ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE ( ) _____ SPECIAL NOTES _____

MEDICAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

◇ AIDS	◇ Diabetes	◇ HIV Infection
◇ Anemia	◇ Emotional Problems	◇ Kidney Disorders
◇ Arthritis	◇ Endocrine Disorders	◇ Latex Sensitivity
◇ Artificial Heart Valve	◇ Epilepsy (Convulsions)	◇ Liver Disease
◇ Artificial Joints	◇ Frequent Headaches	◇ Mitral Valve Prolapse
◇ Asthma	◇ Glaucoma	◇ Neurologic Discorders
◇ Blood Disorders	◇ Heart Murmur/Heart Problems	◇ Respiratory Problems
◇ Blood Transfusions	◇ Hemophilia	◇ Rheumatic Fever
◇ Bruise Easily	◇ Hepatitis	◇ Thyroid Problems
◇ Cerebral Palsy	◇ Herpes	◇ Tonsil or Adenoid Removal
◇ Congenital Heart Disease	◇ High Blood Pressure	◇ Tuberculosis

PATIENT'S PHYSICIAN _____

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN _____

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING _____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

_____

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES OR NO) _____

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE _____

_____

WOMEN: ARE YOU PREGNANT AT THIS TIME? _____

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

◇ Bleeding Gums	◇ Jaw Joint Pain	◇ Nail Biting
◇ Chronic Facial Pain	◇ Jaw Joints Pop or Click	◇ Periodontal Surgery
◇ Clenching or Grinding of Teeth	◇ Jaw Locking Open or Closed	◇ Permanent Teeth Removed
◇ Difficulty Chewing or Swallowing	◇ Limitation in Mouth Opening	◇ Speech Problems
◇ Dizziness	◇ Missing or Extra Permanent Teeth	◇ Sucks Thumb, Finger or Lip
◇ Frequent Headaches	◇ Mouth Bleeding	◇ Teeth Sensitivity - Hot/Cold
◇ Injuries to Face or Teeth	◇ Muscle Tenderness in Jaw or Neck	◇ Tongue Thrust

PATIENT'S DENTIST _____ DATE OF LAST CLEANING ___/___/___

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT _____

HAS THE PATIENT RECEIVED AN EVALUATION OR TREATMENT IN ANOTHER ORTHODONTIC OFFICE? (YES OR NO) _____

IF YES, BY WHOM? _____

LIST THE PATIENT'S CHIEF CONCERNS AND WHAT THEY WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH _____

_____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Kozak and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment.

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ **DATE** _____

FOR OFFICE USE
UPDATES (DATE AND INITIAL)