Robert Kent and Associates, DDS

Orthodontics for Children & Adults

Patient Information Form

About You

Name:
Home Address:
Home Number:
Work Number: Cell Number
Birthday: Male ☐ Female ☐
SSN:
Single ☐ Married ☐ Partnered ☐
Divorced/Separated ☐ Widowed ☐
Email Address:

General Information

General Dentist:

When was your last visit?

Whom may we thank for referring you?

Other family members seen by us:

Names and ages of siblings:

Patient Information

Parent's Marital Status: Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐

Who is responsible for the account?

Self ☐ Father ☐ Step Father ☐ Guardian ☐ Spouse ☐
Name:
Birthday: SSN:
Address (if different from child's)

Email:
Home Number:
Work Number: Cell Number:
Employer: Occupation:
Do you have dental insurance? Yes ☐ No ☐
Insurance co. name:
Insurance co. phone#:
Insurance co. address:
Subscriber Number:
Group Number:

Self ☐ Mother ☐ Step Mother ☐ Guardian ☐ Spouse ☐
Name:
Birthday: SSN:
Address (if different from child's)

Email:
Home Number:
Work Number: Cell Number:
Employer: Occupation:
Do you have dental insurance? Yes ☐ No ☐
Insurance co. name:
Insurance co. phone#:
Insurance co. address:
Subscriber Number:
Group Number:

Dental/Medical History

What are the main concerns that you would like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment?....................................Yes ❑ No ❑

Have you ever had a serious/difficult problem associated with any previous dental work? ....Yes ❑ No ❑

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes ❑ No ❑

Do you still have wisdom teeth?.........................Yes ❑ No ❑

Have you ever had an injury to your: ....Mouth ❑ Teeth ❑ Chin ❑

Do you require antibiotics before dental treatment?..Yes ❑ No ❑

Have your tonsils been removed?.......................Yes ❑ No ❑

Do you generally breathe through your mouth while awake?..Yes ❑ No ❑

Do you generally breathe through your mouth while asleep?..Yes ❑ No ❑

Do you have any missing or extra permanent teeth? ....Yes ❑ No ❑

Have you experienced any of the following?

Y ❑ N ❑ Clenching/Grinding teeth
Y ❑ N ❑ Pacifier use extended
Y ❑ N ❑ Lip sucking/biting
Y ❑ N ❑ Thumb/Finger sucking
Y ❑ N ❑ Nail Biting
Y ❑ N ❑ Speech problems
Y ❑ N ❑ Mouth Breather
Y ❑ N ❑ Tongue Thrust

Are you happy with the way your smile looks? Yes ❑ No ❑
If not, what would you change?

Have you every had any of the following conditions:

Y ❑ N ❑ Abnormal Bleeding
Y ❑ N ❑ Prosthetics
Y ❑ N ❑ Hearing Impairment
Y ❑ N ❑ ADD/ADHD
Y ❑ N ❑ AIDS/HIV+
Y ❑ N ❑ Kidney Problems
Y ❑ N ❑ Mitral Valve Prolapse
Y ❑ N ❑ Congenital Heart Defect
Y ❑ N ❑ Rheumatic Fever
Y ❑ N ❑ Blood Transfusion
Y ❑ N ❑ Handicaps/Disabilities
Y ❑ N ❑ Sickle Cell Disease/Traits
Y ❑ N ❑ Oral Herpes / Fever Blisters
Y ❑ N ❑ Artificial Bones/Joints/Valves
Y ❑ N ❑ Any Hospital Stays/Operations
Y ❑ N ❑ Hemophilia
Y ❑ N ❑ Arthritis
Y ❑ N ❑ Cancer
Y ❑ N ❑ Heart Murmur
Y ❑ N ❑ Hepatitis
Y ❑ N ❑ Asthma
Y ❑ N ❑ Liver Problems
Y ❑ N ❑ Convulsions
Y ❑ N ❑ Diabetes
Y ❑ N ❑ Epilepsy

Are your immunizations current?.......................Yes ❑ No ❑

Is there anything you would like to discuss with the doctor in private? ....Yes ❑ No ❑

Please list any serious medical condition(s):

Please list any other drugs/materials that you are allergic to:

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 of confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents 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. PAYMENT IS DUE AT THE TIME OF TREATMENT (unless prior arrangements have been approved.)

Signature:______________________________ Date: ______________

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I herby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize the release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature:______________________________ Date: ______________

OFFICIAL USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials:__________ Date:________________ Doctor's comments:______________________________

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MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?
Yes ❑ No ❑ If Yes, please explain:______________________

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Patient Signature ____________________ Date: __________
Office Signature ____________________ Date: __________

Has there been any change in your health status since your last visit?
Yes ❑ No ❑ If Yes, please explain:______________________

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Patient Signature ____________________ Date: __________
Office Signature ____________________ Date: __________