

Berkinshaw Orthodontics, P.A.
New Patient Information Form (Adult)

Patient's Information:

Patient's Name _____

Nickname _____

Birth Date _____ Age _____ Gender _____ E-mail Address _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ SS# _____

Employer _____ Job Title _____ # of Years _____

Dentist _____ Last Visit _____

Favorite Sports or Hobbies _____

Marital Status: Single Married Divorced Separated Widowed
Whom May We Thank for Referring You to Our Office?

Spouse's Information: (if applicable)

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____ SS# _____

Employer _____ Job Title _____ # of Years _____

Person Financially Responsible for Account (if not Patient)

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Home # _____ Work # _____ SS# _____

Employer _____ Title _____ # of Years _____

Orthodontic Insurance Information

Primary Insurance Company _____ Group # _____ Phone # _____

Insured's Name _____ Birth Date _____

Employer _____ SS# _____

Secondary Insurance Company _____ Group # _____ Phone # _____

Insured's Name _____ Birth Date _____

Employer _____ SS# _____

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

Signature

Health History

If the **Patient HAS** or **HAS HAD** any of the following, please indicate:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Frequently stuffed nose | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Drug Sensitivities | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Thumb or Finger Sucking | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Previous orthodontic treatment | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> "Mouth Breather" | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Pregnant (presently) |

1. Does the patient have any special problems not listed above? Yes___ No___

Explain

2. Does the patient experience any pain of clicking in the jaws upon opening and/or closing?

Yes___ No___ Explain

3. Has the patient been under the care of a physician during the past two years (other than routine checks)? Yes___ No___ Explain

3. Is the patient taking any medications? Yes___ No___ Please List Medications and Reason

For Taking Them
