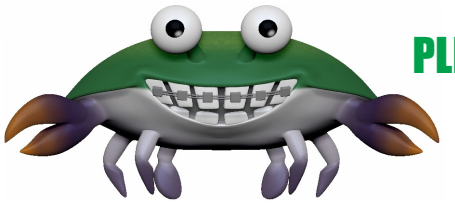
Welcome to our practice!



PLEASE FILL OUT ALL THREE PAGES

Today's Date:_____

Name:_____Preferred Name:_____
LAST, FIRST MI

Birthday:____/_____/_____ Age:_____ Pronouns:_____

Gender on File with Insurance: M ( ) F ( ) Other ( )

Marital Status: Single { } Married { } Civil Union { } Widowed { } Divorced { } Separated { }

Home Address _____City_____Zip_____

Cell#: (_____)_____ Work# (_____)_____ Email:_____

Where and when are the best times to reach you?:_____

Employer: _____ Occupation:_____

General Dentist _____ Date of Last Dental Visit: _____

Who may we thank for referring you? _____

Who is responsible for account:

Guarantor Name:_____Birthdate:_____

Address: (If different than above) _____

Home # _____ Cell # _____ Email _____

Employer: _____Occupation: _____Work # _____

In the event of an emergency, please contact:

Name:_____ Relation:_____ Phone:_____

Insurance Information:

Orthodontic Coverage Yes No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Secondary Orthodontic Coverage Yes No

Insured's Name: _____ Relation: _____ Birthdate: _____

Insurance Co.: _____Group #: _____Policy #: _____

Medical History

Are you currently taking medications/over-the-counter drugs (including vitamins/supplements)? Yes No

If so, please list here:_____

Are you allergic to any medications or dental products? Yes No

If so, please list here: _____

Are you under the care of a physician? Yes No

Physician's Name: _____ Phone _____

Is there a possibility that you are currently pregnant? Yes No

Are you taking birth control pills? Yes No

Please list any serious medical condition(s) that you have ever had:

_____

_____

Have you experienced any of the following:

Yes	No	Abnormal bleeding/Hemophilia	Yes	No	Convulsions
Yes	No	Heart murmur	Yes	No	Prosthetics
Yes	No	ADD/ADHD	Yes	No	Diabetes
Yes	No	Heart Surgery/Pacemaker	Yes	No	Rheumatic Fever
Yes	No	AIDS/HIV+	Yes	No	Epilepsy
Yes	No	Any hospital stay/operations	Yes	No	Scarlet Fever
Yes	No	Hepatitis	Yes	No	Frequent headaches
Yes	No	Arthritis	Yes	No	Seizures/Fainting
Yes	No	Herpes/Fever blisters	Yes	No	Handicaps/Disabilities
Yes	No	High/Low blood pressure	Yes	No	Hay fever
Yes	No	Kidney problems	Yes	No	Sickle cell disease/traits
Yes	No	Cancer	Yes	No	Hearing impairment
Yes	No	Bone Disorders	Yes	No	Tuberculosis (TB)
Yes	No	Vertigo	Yes	No	Heart attack/Stroke

Other (please specify): _____

Do you have allergies to any of the following:

Yes	No	Local anesthetics	Yes	No	Latex
Yes	No	Aspirin	Yes	No	Metals
Yes	No	Ibuprofen	Yes	No	Codeine or other narcotics
Yes	No	Sulfa Drugs	Yes	No	Acrylic
Yes	No	Food (specify):	Yes	No	Animals

Other (specify): _____

Dental History

Yes No Have you ever been evaluated or had orthodontic treatment before?
Yes No Have you seen a general dentist in the last 6 months?
Yes No Have there been any injuries to the face, mouth, teeth or chin?
Yes No Do you require antibiotics before dental treatment?
Yes No Do you smoke or use tobacco in any form?
Yes No Have you ever had difficulties associated with previous dental work?
Yes No Do you have any pain/tenderness in his/her jaw joint (TMJ/TMD)?
Yes No Do you brush and floss your teeth daily?
Yes No Are you aware of any "gum" problems?
Yes No Do you have any of the following habits? (If so, please circle)

Clenching/Grinding teeth	nail biting	thumb/finger sucking
Lip sucking/biting	tongue thrust	mouth breather

Why have you come to see Dr. Koterwas today? i.e. crowding, overbite, etc...

_____

Please Initial the Following & Sign

_____ 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 that it is my responsibility to inform this office of any changes in my status **including insurance assignment**. I authorize the dental staff to perform the necessary dental/orthodontic services I may need.

_____ I authorize Dr. Koterwas Orthodontics to communicate with my general dentist and/or other healthcare providers involved in my treatment. This includes x-rays, medical record information or any relevant documentation deemed necessary to render treatment and coordinate care for the patient.

_____ I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____ I hereby authorize Dr. Koterwas Orthodontics, DDS, LLC and/or Koterwas Orthodontics of Prince Frederick to release all information necessary to secure the payment of benefits. I also assign, directly to the doctor, all insurance benefits otherwise payable to me.

_____

Patient Signature Date

At Koterwas Orthodontics it is our motto that **Kindness Matters** and everyone is special, unique and has something positive to contribute to the world. Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.