NEWBURY PARK ORTHODONTICS

CORY HOFFMAN, D.D.S, C.A.G.S.

Today's Date: _____

PATIENT INFORMATION

Name: _____

Address: _____
Street City Zip

Home Phone: _____ Birthdate: _____ SS#: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Whom may we Thank for referring you to our office? _____

List all siblings with age: _____

What are your main concerns?:

_____

RESPONSIBLE PARTY INFORMATION

Name: _____ E-mail address: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS#: _____ Relationship to Patient: _____

Employer: _____

Spouse's Name: _____

ORTHODONTIC INSURANCE

Dental Insurance Company: _____ Group Plan#: _____

Policy Owner's Name: _____ Policy Owner's Birthdate: _____

Policy Owner's SS#: _____ Policy ID#: _____

Policy Owner's Employer: _____ Relationship to Patient: _____

DENTAL HISTORY

Patient's Dentist: _____ Date Last Seen: _____

	Yes	No
Have there been any injuries to the face, mouth, or teeth?		
Has the patient ever sucked a thumb or finger? Until what age? _____		
Does the patient have any clicking or discomfort in the jaw joints (TMJ / TMD)?		
Have you been informed of any missing or extra teeth?		
Has the patient ever been evaluated or had orthodontic treatment before?		
Does the patient clench or grind his/her teeth?		
Does the patient have any speech problems?		

MEDICAL HISTORY

Has the patient ever been treated for any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			Asthma			Hemophilia		
ADD / ADHD			Cancer			Hepatitis		
Allergic to any Drugs			Congenital Heart Defect			HIV+ / AIDS		
Allergic to Latex / Metals			Convulsions / Epilepsy			Kidney / Liver Problems		
Allergic to Plastic			Diabetes			Lupus		
Any Hospital Stays			Handicaps / Disabilities			Rheumatic / Scarlet Fever		
Any Operations			Hearing Impairment			Tuberculosis (TB)		
Artificial Bones / Joints / Valves			Heart Murmur					

Please list all medications that the patient is currently taking:_____

_____

If checked "YES" to any above, please describe:

_____

I understand that the information that 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 the patient's medical status.

I authorize the dental staff to perform the necessary dental services that the patient may need.

INSURANCE ASSIGNMENT AND RELEASE – I, the undersigned, assign directly to NEWBURY PARK ORTHODONTICS all insurance benefits, otherwise payable to me for services rendered.
I also hereby authorize NEWBURY PARK ORTHODONTICS to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

_____ _____

Signature (parent or guardian if patient is a minor) Date