

Please complete both sides and return form to our office prior to appointment.

Thomas J. Huerter, DDS, MS

PATIENT INFORMATION

Patient's Name: _____
Date of Birth: _____ Sex M F Marital Status: Single Married Widowed Divorced Separated
Home Address: _____
Home Phone: _____ Occupation: _____
Employer: _____ Work Phone: _____ Cell Phone: _____
Work Address: _____
In case of emergency, please notify: _____ Relationship: _____ Phone: _____

If Patient is a Minor Information

Mother's Name: _____ DOB _____ SOCIAL SECURITY NUMBER _____
Mother's Address: _____ Home Phone: _____
Mother's Employer: _____ Occupation: _____ Cell Phone: _____
Work Address: _____ Work Phone: _____
Father's Name: _____ DOB _____ SOCIAL SECURITY NUMBER _____
Father's Address: _____ Home Phone: _____
Father's Employer: _____ Occupation: _____ Cell Phone: _____
Work Address: _____ Work Phone: _____

If Patient is Married Information

Spouse's Name: _____ Social Security Number: _____
Spouse's Employer: _____ Occupation: _____
Work Address: _____ Work Phone: _____

Orthodontic Insurance information required prior to appointment, please complete before mailing

INSURANCE INFORMATION

Primary Carrier

Patient Name _____
Employee Name _____
Employee Birth Date _____
Insurance ID# _____
Insurance Carrier _____
Insurance Carrier Address _____
City, State, Zip _____
Insurance Carrier Phone _____
Employer _____
Employer Address _____
City, State, Zip _____
Employer Phone _____
Group Number _____

Secondary Carrier

Patient Name _____
Employee Name _____
Employee Birth Date _____
Insurance ID# _____
Insurance Carrier _____
Insurance Carrier Address _____
City, State, Zip _____
Insurance Carrier Phone _____
Employer _____
Employer Address _____
City, State, Zip _____
Employer Phone _____
Group Number _____

AUTHORIZATION:

I understand that I am financially responsible for all charges incurred for orthodontic services. It is our office policy that the parent who requests services for the child and who brings the child into the office is responsible for all fees for services rendered.

I authorize and request that payment be made directly to this practice for services rendered.

I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

I authorize the release of any information required to process a claim.

Signature: _____ Date: _____ For Office Use _____

MEDICAL INFORMATION

- 1) Is the patient allergic to any drugs, foods, or latex?Yes No If yes, what? _____
- 2) Is the patient presently under the care of a physician?Yes No If yes, for what reason? _____
-
- 3) At the present time is the patient taking any medication? ..Yes No If yes, for what reason? _____
-
- 4) Does the patient have a history of heart disease?Yes No Need Premedication?Yes No

PERSONAL INFORMATION

- 1) What is the main problem as you see it? _____
- 2) Are you self conscious about your teeth? _____
- 3) Have any other family members received treatment in our office? ..Yes No Name(s) _____
- 4) Has any member of your family had:
- A similar dental condition?Yes No
 - Similar facial appearance?Yes No
- 5) Is the patient:
- Having any dental problems at this time?Yes No
 - Seeing the dentist more than once a year?Yes No
 - Apprehensive about receiving dental care?Yes No
 - Experiencing any discomfort from your teeth? ...Yes No
 - Experiencing any discomfort from your gums? ...Yes No
- 6) Do any of the following apply to the patient:
- Previous orthodontic therapyYes No
 - Teeth that are shiftingYes No
 - Thumb or Finger sucking habit as a childYes No
 - Soreness of jaw muscles or jaw jointYes No
 - Clenching your teethYes No
 - Grinding your teethYes No
 - Traumatic injury involving teethYes No
- 7) Patient's Dentist Name _____ City/State _____
- Phone number _____ Date of Last Dental Exam _____
- 8) Who can we thank for your referral to our office? _____

Comments _____

E-mail address for appointment confirmations _____