PATIENT REGISTRATION (Please complete form in ink)

Today's Date _____

Bielas ORTHODONTICS

PATIENT INFORMATION

Name (Last/First/M.I.) _____ Preferred Name _____

Sex M F Birthdate _____ Age _____ Referred by _____

Reason for this visit _____

RESPONSIBLE PARTY INFORMATION

Name (Last/First/M.I.) _____ Relation to Patient _____

SS # _____ Birthdate _____ Marital Status _____

Residential Address _____

Mailing Address _____

Phone (H) _____ Phone (W) _____

Phone (C) _____ Email Address _____

Employer _____ Occupation _____

Name of Spouse (Last/First/M.I.) _____ Relation to Patient _____

SS # _____ Birthdate _____ Marital Status _____

Phone (C) _____ Phone (W) _____

Employer _____ Occupation _____

ADDITIONAL PARENT/GUARDIAN INFORMATION

Please complete if patient is a minor and there are additional parents and/or guardians not listed above

Name (Last/First/M.I.) _____ Relation to Patient _____

SS # _____ Birthdate _____ Marital Status _____

Residential Address _____

Mailing Address _____

Phone (H) _____ Phone (W) _____

Phone (C) _____ Email Address _____

Employer _____ Occupation _____

Name of Spouse (Last/First/M.I.) _____ Relation to Patient _____

SS # _____ Birthdate _____ Marital Status _____

Phone (C) _____ Phone (W) _____

Employer _____ Occupation _____

☐ I give my consent for information and correspondence to be transmitted to me by e-mail, text message and/or voicemail.

This office reserves the right to verify the credit status of potential patients and/or parents/guardians of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Patient Name _____ Birthdate _____

DENTAL HISTORY

Dentist _____

Date of your last dental visit? _____ Reason for last dental visit? _____

Have you ever had a panoramic x-ray?	Yes	No	Date _____
Do you have any dental problems?	Yes	No	Describe _____
Do you have difficulty breathing through your nose?	Yes	No	
Do you tend to breathe through your mouth while sleeping?	Yes	No	
Have you ever had a habit of thumb/finger sucking?	Yes	No	
Have you ever had any symptoms in your jaw joint (TMJ)?	Yes	No	Describe _____
Are you aware of grinding or clenching your teeth?	Yes	No	
Do you have headaches or neck pains?	Yes	No	Frequency _____
Have you pierced your tongue?	Yes	No	
Have you had any previous orthodontic treatment?	Yes	No	
Would you like your smile to look better or different?	Yes	No	Describe _____

Are there any restrictions, handicaps or problems that might be encountered during treatment? (Successful treatment greatly depends on the patient's complete cooperation in following instruction, keeping appointments, and maintaining oral hygiene).

Yes No Describe _____

MEDICAL HISTORY

Primary Care Physician _____

Do you have any current health problems?	Yes	No	Describe _____
Are you currently under a physician's care?	Yes	No	Explain _____

What medications and herbal remedies are you currently taking, including over-the-counter? _____

_____

Females: Are you pregnant?	Yes	No	
Do you use tobacco?	Yes	No	Frequency _____

Are you allergic to or have you reacted adversely to any of the following? Aspirin Ibuprofen Latex Metal/Nickel Penicillin

No Known Allergies Other (list any other allergies to medications or substances) _____

Check any of the following which you have had, or presently have:

- ☐ AIDS/HIV pos.
- ☐ Allergies or Hayfever
- ☐ Anemia
- ☐ Anxiety/Nervous disorder
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Bisphosphonates/Osteoporosis treatment
- ☐ Bleeding problems
- ☐ Bone disorders
- ☐ Cancer or tumor
- ☐ Chemotherapy/Radiation
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Gastrointestinal disorders
- ☐ Heart defect
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart trouble
- ☐ Hepatitis/Type____
- ☐ High blood pressure
- ☐ Hives
- ☐ Joint replacement
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Psychiatric treatment
- ☐ Rheumatic Fever
- ☐ Sexually transmitted diseases
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Tuberculosis

Is there any other medical or dental information that you feel I should know about? Yes No

Explain _____

Patient Name _____ Birthdate _____

ORTHODONTIC INSURANCE COVERAGE

Primary Yes No

Name of Insured (Last/First/M.I.) _____ Birthdate _____ SS #_____

Employer _____ Group #_____

Insurance Co. _____ Insurance Phone _____

Insurance Address _____

Secondary Yes No

Name of Insured (Last/First/M.I.) _____ Birthdate _____ SS #_____

Employer _____ Group #_____

Insurance Co. _____ Insurance Phone _____

Insurance Address _____

☐ I understand that insurance claims may be submitted electronically on my behalf by Bielas Orthodontics.

EMERGENCY CONTACT INFORMATION Relative or friend not living with you

Name _____ Relation to Patient _____

Phone (H) _____ Phone (C) _____

Address _____

☐ I understand that records may be transmitted electronically to other providers for the purpose of treatment, payment and/or operations. I am aware that e-mail is not a secure form of communication.

I have read and understand the above questions. I will not hold Dr. Bielas or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice. I authorize Dr. Bielas and her staff members to take x-rays, study models, photos and any other diagnostic records deemed appropriate in making a thorough diagnosis and formulating a treatment plan.

SIGNATURES

Patient/Guardian's Signature _____ Date_____

Relation to Patient _____

UPDATES

Date	Changes	Per	Initials