KIZIOR ORTHODONTICS PATIENT INFORMATION FORM.
We would like you to provide us, as completely and accurately as possible, the following information.
The information requested below is very important to our providing optimal care for you and it will be held in strictest confidence. Thank you.

Patient Name: _____ Preferred Name: _____ Gender: M F
Last First Middle Initial

Is Patient a Minor/under age 18? **Yes** ☐ **No** ☐ Birth Date: ____/____/____ Age: _____ Is Patient Adopted? **Yes** ☐ **No** ☐

Home Phone:_____ Home Address:_____ City:_____ State:_____ Zip: _____

How would you like to receive appointment reminders: ☐ Cell Phone: _____ Cell Carrier: _____

☐ Email: _____

Name and Ages of Other Children in Family: _____

Other Family Members Seen by Us: _____ Whom May We Thank for Referring You: _____

If Patient is Employed - Employer: _____ Patient's Social Security #: _____

Husband ☐ ***Father*** ☐ ***Step Father*** ☐ ***Guardian*** ☐

Name: _____
Last First Middle Initial

Check if Address is the Same as Patient ☐

Address: _____City/State/Zip:_____
(Complete only if different from patient's information)

Cell Phone: _____ Cell Carrier: _____

Email: _____

Birth Date:____/____/____ Social Security #: _____

Employer: _____ Employer Phone: _____

Wife ☐ ***Mother*** ☐ ***Step Mother*** ☐ ***Guardian*** ☐

Name: _____
Last First Middle Initial

Check if Address is the Same as Patient ☐

Address: _____City/State/Zip:_____
(Complete only if different from patient's information)

Cell Phone: _____ Cell Carrier: _____

Email: _____

Birth Date:____/____/____ Social Security #: _____

Employer: _____ Employer Phone: _____

BILLING INFORMATION

*It is our goal to make financial arrangements as convenient as possible for all concerned. So that your **account and contract** may be created in the correct fashion, please complete the following for us:*

Person(s) Financially Responsible for this Account (The account will be set up in this name): _____

Relationship to Patient: _____ Person(s) Financially Responsible are: Married ☐ Separated ☐ Divorced ☐ Do Not Live Together ☐

Phone: _____ Address: _____ City/State/Zip: _____

(Complete only if different from patient's information)

INSURANCE INFORMATION

*As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us with **accurate and up-to-date** insurance information. Please complete **ALL** lines and bring your **DENTAL** insurance card(s) with you at this appointment. A copy will be made for the patient's file.*

Primary Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth Date: ____/____/____ Social Security #: _____ Employer: _____

Insurance Company Name: _____ Orthodontic Coverage: **Yes** ☐ **No** ☐

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Group #: _____ Member ID#: _____

Secondary Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth Date: ____/____/____ Social Security #: _____ Employer: _____

Insurance Company Name: _____ Orthodontic Coverage: **Yes** ☐ **No** ☐

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Group #: _____ Member ID#: _____

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan, depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance in not designed to provide 100% benefit, but rather is meant to assist in the cost of orthodontic care. We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed. You are personally responsible for your account, and encourage you to contact your insurance company if they have not paid within 30 days.

MEDICAL/DENTAL/ORTHODONTIC HISTORY

Please ***COMPLETE*** *the following questions-* ***CHECK*** *Yes* ***OR*** *No* ***and fill in any additional information.***

Patient's Physician: _____ Physician's Address: _____

Are you being treated by any physicians at this time? **Yes** ☐ **No** ☐ If yes, please list why: _____

Has the patient reached puberty? (Helps determine jaw growth) **Yes** ☐ **No** ☐ Females — Are you pregnant? **Yes** ☐ **No** ☐

Are you currently taking any medication? If yes, please list:

Name: _____ How Long: _____ Why: _____

Name: _____ How Long: _____ Why: _____

Does your physician require you to have an antibiotic before dental procedures? **Yes** ☐ **No** ☐

Do you have any allergies Latex? **Yes** ☐ **No** ☐ Metals? **Yes** ☐ **No** ☐

Please list any other allergies or drug sensitivity To what: _____ Age: _____ Reaction: _____

Do you have any history of the following conditions? Please check Yes OR No

	Yes	No		Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Hepatitis/Liver Disease	☐	☐	Speech Difficulties	☐	☐	Hearing/Ear Problems	☐	☐
Emotional Difficulties	☐	☐	Fainting or Dizziness	☐	☐	Heart Problems	☐	☐	Heart Murmur	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐	Bleeding Problems	☐	☐	Kidney Disease	☐	☐
Birth Defects	☐	☐	High Blood Pressure	☐	☐	Asthma or Wheezing	☐	☐	Epilepsy or Seizures	☐	☐
Anemia	☐	☐	HIV/AIDS	☐	☐	Arthritis/Bone-Joint Problems	☐	☐			

ANY OTHER MEDICAL CONDITIONS: _____

Patient's Dentist: _____ Dentist's Address: _____

Do you have any of the following conditions: Jaw Joint Noises? **Yes** ☐ **No** ☐ Jaw Pain? **Yes** ☐ **No** ☐ Bleeding Gums? **Yes** ☐ **No** ☐

Difficulty Chewing or Opening Your Mouth Wide? **Yes** ☐ **No** ☐ Headaches? **Yes** ☐ **No** ☐ Sensitive Teeth? **Yes** ☐ **No** ☐

Have your teeth and/or mouth been injured in the past? **Yes** ☐ **No** ☐

If yes, what was the cause of injury: _____

How old were you at the time?: _____ Which teeth and/or area of mouth were injured?: _____

Has the patient had, or does he/she have any of the following habits? Please check Yes OR No

	Yes	No		Yes	No		Yes	No
Lip Biting/Sucking	☐	☐	Constant Mouth Breathing	☐	☐	Tongue Thrusting	☐	☐
Teeth Grinding/Clenching	☐	☐	Cheek or Nail Biting	☐	☐	Finger/Thumb/Blanket Sucking	☐	☐

What is the reason for seeking orthodontic care?: _____

Does anyone else in the family have a similar orthodontic condition? **Yes** ☐ **No** ☐ Who?: _____

Has anyone else in the family received orthodontic care? **Yes** ☐ **No** ☐

Who?: _____ Name of orthodontist?: _____

Has an orthodontist been consulted previously? **Yes** ☐ **No** ☐

How well do you think the patient will react to orthodontic treatment? Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know ☐

Are there any other dental conditions or symptoms that you feel we should know about? **Yes** ☐ **No** ☐

If yes, please list: _____

_____

Additional Comments: _____

May we use the patient's photo to be displayed on our Social Media sites (Facebook, Instagram, Website) as a means of congratulating them on starting treatment or showcasing their newly straightened smile after their braces are off? **Yes** ☐ **No** ☐

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the orthodontic staff to perform any necessary orthodontic services that may be needed during diagnosis and treatment with my informed consent.
Thank you for being so cooperative in answering the above questions. We look forward to providing the highest orthodontic care for the patient.

Adult Patient or Parent/Guardian Signature: _____ **Relationship to Patient:** _____ **Date:** ___/___/___