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LASLOVICH
ORTHODONTICS

Welcome! We love seeing new patient, and we're excited to talk with you about your family's orthodontic care. We understand the importance of choosing an office that truly cares about the quality of service it provides. That's why we go to great lengths to make sure that your experience with us is a pleasant one. Please take a few minutes to **fill out this patient history form as completely as possible**. If you have questions, we'll be glad to help you .

Date_____

Patient Information

Name_____ Age_____ Date of Birth_____ Male __ Female ____
Address_____ City_____ State_____ Zip _____
How long at this address?_____ Home Phone _____
Mailing Address (if different from residence)_____
Email _____
Address_____
General Dentist_____ Date of most recent dental exam_____

Responsible Party Information

Name_____ Date of Birth_____Social Security # _____
Address_____ City_____ State_____ Zip _____
Home Phone_____ Cell Phone _____
Email Address_____
Employer_____ Occupation_____
Work Phone_____ # of Years Employed _____
Relationship to Patient _____

Spouse Name_____ Date of Birth_____Social Security # _____
Address_____ City_____ State_____ Zip _____
Home Phone_____ Cell Phone _____
Email Address_____
Employer_____ Occupation_____
Work Phone_____ # of Years Employed _____
Relationship to Patient _____

Dental Insurance Information

Primary Insurance
Insured's Name_____Date of Birth_____Social Security # _____
Insurance Company_____ Group # _____
Insurance Company Address _____
Insurance Company Phone_____ Insured's Employer _____
Do you have dual coverage? Yes____ No____ If yes, complete the following:

Secondary Insurance
Insured's Name_____Date of Birth_____Social Security # _____
Insurance Company_____ Group # _____
Insurance Company Address _____
Insurance Company Phone_____ Insured's Employer _____

Emergency Contact Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Patient's Medical History

Have you been under the care of a physician in the last two years? Yes____ No____

Child's Physician _____

Have you ever had or do you now have any of the following:

___ Prolonged Bleeding
___ Epilepsy
___ Heart Murmur
___ Heart Problems
___ Rheumatic Fever
___ Bone Disorders
___ Tuberculosis
___ Hepatitis
___ AIDS or HIV
___ Diabetes
___ Cancer
___ Anemia
___ Asthma
___ Fainting or Dizziness
___ Nervous Disorder
___ Endocrine Problems
___ Liver Problems
___ Birth Defects
___ Allergies
___ Latex Allergy

___ Have you had any operations? Yes____ No____

___ Have you been hospitalized? Yes____ No____

___ List any medications you are now on:

_____

_____

___ List any medications you are allergic to:

_____

_____

Any other conditions we should know about? _____

Has puberty begun? Yes____ No____ Has menstruation (period) begun? Yes____ No____ N/ A____

Patient's Dental History

Do you have any of the following:

___ ***Any family members who have had orthodontics in our office*** _____

___ Teeth sensitivity to hot/cold
___ Injuries to your face, jaw, mouth, or teeth
___ Bleeding gums, bad taste in mouth
___ Root canals, crowns, or bridges
___ Suck your thumb and/or fingers
___ Any clicking, popping, or pain of the jaw/joints (TMJ)
___ Any missing or extra teeth
___ Trouble chewing

How often do you brush your teeth?_____ How often do you floss your teeth?_____

What is your main concern that you would like to discuss at today's initial examination and what would you like to change about your smile? _____

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

I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment whether or not paid by insurance. I here by authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I authorize the use of this signature on all insurance submissions, whether filed manually or electronically. The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the dental staff to perform any necessary dental services that I, or my child, may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment. I further agree to pay all finance charges, collection costs, attorney's fees, and any other cost that may be incurred to enforce collection of any outstanding balance and authorize credit bureau reports to be obtained for collection purposes.

Signature of Parent or Legal Guardian_____ Date_____