



## Dunn & Schreiber Orthodontics, PC

Patient's Name: \_\_\_\_\_ Patient's preferred name \_\_\_\_\_ Age \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Married \_\_\_ Single \_\_\_ Child \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Patient's School/Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Medical/Dental History

Reason for seeking orthodontic treatment \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ City \_\_\_\_\_ Last Visit \_\_\_\_\_

Has anyone in your family ever had orthodontic treatment? \_\_\_\_\_ In this office? \_\_\_\_\_

Does this family anticipate a move in the next 2-3 years? \_\_\_\_\_

Patient's physician \_\_\_\_\_ City \_\_\_\_\_ Last visit \_\_\_\_\_

Rate the patient's health \_\_\_Excellent \_\_\_Good \_\_\_Fair \_\_\_Poor

Has the patient been under a physician's care during the past 5 years, been hospitalized, or had any serious illness?  
\_\_\_\_\_ If yes, explain \_\_\_\_\_

Has the patient had a blood transfusion? \_\_\_\_\_ When? \_\_\_\_\_

Is the patient allergic to any medication or substance? \_\_\_Yes \_\_\_ No If yes, please name: \_\_\_\_\_

Name any medications the patient is currently taking \_\_\_\_\_

Has patient ever had any of the following? Please circle any that apply:

- |                     |                        |                  |                      |
|---------------------|------------------------|------------------|----------------------|
| Abnormal Bleeding   | Endocrine disturbance  | Heart murmur     | Hemodialysis         |
| Hemophilia          | Growth disturbance     | Rheumatic fever  | AIDS/ARC             |
| Anemia              | Low Blood Pressure     | Prosthetic joint | HIV                  |
| Bruise easily       | Cancer                 | Kidney disease   | Severe headaches     |
| Asthma              | Chemotherapy           | Liver disease    | Auto accident injury |
| Breathing Problems  | Radiation Therapy      | Scarlet fever    | Tobacco (any form)   |
| Allergies           | Thyroid disease        | Epilepsy         | Hepatitis            |
| High Blood pressure | Diabetes               | Convulsions      | Herpes               |
| ADD/ADHD            | Bone disease           | Fainting spells  | Pregnancy            |
| Autism              | Frequent urination     | Ulcers           |                      |
| Down's Syndrome     | Excessive thirst       | Tuberculosis     |                      |
| Behavioral problems | Heart disease          | Persistent cough |                      |
| Birth Defects       | Prosthetic heart valve | Rickets          |                      |

**Spouse or Parent Information**

Mother/Wife's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Birth Date \_\_\_\_\_ Driver's License # \_\_\_\_\_ Employer \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_  
Street City/State Zip Code

Father/Husband's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Birth Date \_\_\_\_\_ Driver's License # \_\_\_\_\_ Employer \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_  
Street City/State Zip Code

**Insurance Information**

Name of Insured \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Address \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Employer's address \_\_\_\_\_

Patient's relationship to insured: \_\_\_Self \_\_\_Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

**Consent for Services**

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Dr. S. Kendall Dunn or Dr. Alex C. Schreiber all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of the signature on all insurance claims.

I hereby consent to treatment for myself, my child, or the above named minor, for whom I am legally responsible. The release of orthodontic information for insurance claims, the release of past medical payment history/credit history if requested, is authorized. I hereby acknowledge and accept full and final responsibility for payment of charges for orthodontic services rendered. I understand that if payments for further collection agency for further collection activity. I agree the fee charged is a legal and lawful debt and I agree to be responsible for any and all collection fees, attorney fees, and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the Constitution of Alabama or any other state.

I, the undersigned, give my permission to Dr. S. Kendall Dunn and Dr. Alex C. Schreiber to give the requested orthodontic care to myself/my child.

Signature of person filling out form \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_