ORTHODONTIC ASSOCIATES
of CENTRAL ILLINOIS, PLLC

R.C. Lauder, DDS, MS • **S.M. Peterson,** DDS, MS • **K.E. Finlen,** DDS, MS

Patient ID# _____ Exam Date: _____

Examined by: Dr. _____

Patient Name: _____ DOB: _____ Age: _____

Preferred Name: _____ Phone: ( ) _____

Address: _____ Text reminders: ☐ Carrier: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Employer Name: _____ Occupation _____

Employer Address _____ Phone ( ) _____

Spouse's Name: _____ Employer Name: _____

Employer Address _____ Phone ( ) _____

Who is financially responsible for this account? *(If different from patient.)*

Name: _____ Relationship to patient: _____

Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip: _____

ORTHODONTIC INSURANCE (Primary)

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

ID#: _____

INSURED'S EMPLOYER: _____

ORTHODONTIC INSURANCE (Secondary)

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

ID#: _____

INSURED'S EMPLOYER: _____

I agree to be responsible for all charges for orthodontic services. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature of Patient _____ Date _____

Patient's Name: _____ Preferred Name: _____

Name of General Dentist: _____ Date of last dental cleaning/exam: _____

Name of other family members treated here at Orthodontic Associates: _____

Whom may we thank for referring you? _____

Have you ever had orthodontic treatment or worn a "retainer" or "biteplate" _____ When? _____

Who did the treatment? _____

Do you anticipate a move or transfer in the near future? _____

What is your primary concern (why are you here)? _____

MEDICAL HISTORY

Are you in good health? _____

Are you under a physician's care now? _____ If so, please give reason for treatment. _____

Are you taking any kind of medication now? _____

Have you had any serious illness? _____

Have you ever taken medications for osteoporosis? _____

Do you have any allergies (latex, metal, etc.)? _____

Are you required to take antibiotics before dental appointments? _____

Have you had any facial accidents or trauma? _____

Is there any additional information which should be known about your health? _____

Signature _____ Date _____

Initial Exam

Treatment Fee _____ +I

Recall _____

Will Call _____

Letter to Dentist

Recall Exam

Date

Treatment Fee _____ +I

Recall _____

Will Call _____

Letter to Dentist