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: ______________________ ☐ Male ☐ Female

Address: ______________________ Phone: ( ) ______________

City: ______________ State: ________ Zip: ________ School ______________ Grade: ______

Special Interests/Important Patient Information: ______________________

FATHER'S INFORMATION

NAME: ______________________

BIRTHDAY: ______________________

ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIP: ________

EMAIL: ______________________

PHONE: ( ) ______________________

TEXT REMINDERS: ☐ CARRIER: ______________________

EMPLOYER: ______________________

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

SPOUSE: ______________________

MOTHER'S INFORMATION

NAME: ______________________

BIRTHDAY: ______________________

ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIP: ________

EMAIL: ______________________

PHONE: ( ) ______________________

TEXT REMINDERS: ☐ CARRIER: ______________________

EMPLOYER: ______________________

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

SPOUSE: ______________________

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 Parent/Guardian ______________________ 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? ______________________________

Has the patient ever had orthodontic treatment or worn a "retainer" or "biteplate" ______________ When? ______________

Who did the treatment? ______________________________

How many Brothers?__________ Ages ______________ Sisters?__________ Ages ______________

Height of Patient ________ Still growing?________ Height of Father________ Mother________ Patient adopted? ______

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

What is the patient's (or parent's) primary concern (why are you here)? ______________________________

MEDICAL HISTORY

Is the patient in good health?______________________________

Is the patient under a physician's care now? ______ If so, please give reason for treatment. ______________________________

Is the patient taking any kind of medication now? ______________________________

Has the patient had any serious illness? ______________________________

Does the patient have any allergies (latex, metal, etc.)? ______________________________

Is the patient required to take antibiotics before dental appointments? ______________________________

Has the patient had any facial accidents or trauma? ______________________________

Is there any additional information which should be known about the patient's health?______________________________

Signature______________________________ Date______________ Relationship to Patient ______________

Initial Exam

Treatment Fee ______________ +I

Recall ______________

Will Call ______________

Letter to Dentist

Recall Exam

Date

Treatment Fee ______________ +I

Recall ______________

Will Call ______________

Letter to Dentist

06/21