VERBIC ORTHODONTICS

Confident smiles that last a lifetime

(847) 359-7980

www.palatinebraces.com

New Patient Information

Today's Date:____________ Patient's Name:__________________________

Patient's Birthdate:____/_____/______ Age:______ ____Male ____Female

Residence:____
Street City State Zip Code

Phone:____
Home Cell Work

Medical & Dental History Information

Do any of the following medical problems apply to the patient?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Any hospital stays/operations
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Handicaps/Disabilities:______________
Y N History of Trauma:____

Y N Hearing Impairment
Y N Heart Murmur-
**Is premedication required?____
Y N Mitral Valve Prolapse
Y N Hemophilia
Y N Kidney Problems
Y N Liver Disease
Y N History of snoring
Y N History of sleep apnea
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Tuberculosis (TB)

Please list all drugs that the patient is currently taking:___________________________
Is the patient allergic to any of the following? Please circle what applies- latex/plastics/ metals.
Please list any other allergies?____
Patient's Physician's name:_______________ General Dentist name:_________________
Have adenoids or tonsils been removed?__________ Has puberty begun?______________
Does patient do any of the following? Please circle what applies- nail biting/ tongue thrusting thumb or finger sucking/ mouth breathing/speech problems/clenching or grinding teeth.
Please discuss any serious medical problems the patient has had:_____________________
____
____
Has patient ever had or been evaluated for orthodontic treatment?________ When?_______
What are the main concerns that you would like orthodontics to accomplish?____________
____
____

Visit our website at www.palatinebraces.com & www.barringtonbraces.com

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

(Please Circle One)
Father/Mother/Self:____________________________________ Martial Status_____________
Last First
Residence:____Own__Rent__
Street City State Zip
Phone: Home:______________Cell:________________Work:_____________________

Social Security#__________________________ Birthdate:____________________

Email Address:____

Employer:____No. Year Employed:________
(Please Circle One)
Father/Mother/Spouse:____
Last First
Residence:____
(if different than above) Street City State Zip
Phone: Home:________________Cell:___________________Work:________________

Social Security#________________ Birthdate:__________Employer:_____________________

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

DENTAL INSURANCE INFORMATION

Policy Holder's Name:__________________________________ID/SSN#__________________

Insurance Company:____________________________________Group#___________________

Insurance Co. Address:____
Phone #___________________Policy Holder's Employer:______________________________
Do you have dual coverage?_____Yes_____No If yes, please provide us with that information

EMERGENCY INFORMATION

Name of nearest relative not living with you:_______________________________________
Complete Address:____
Phone:________________________Relationship:__________________________________

I understand that where appropriate, credit bureau reports may be obtained.

Date:___________________________
Signature(Parent's signature if minor)____