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 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)

Y N History of Trauma:____

Has your child told you or do you suspect that your child is being teased because of their smile?__
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:____

Street City State Zip

Phone: Home:_____________________Cell:__________________Work:____________________

Birthdate:__________________Email Address:____

Employer:____

(Please Circle One)

Father/Mother/Spouse:____

Last First

Residence:____

(If different than above) Street City State Zip

Phone: Home:___________________Cell:__________________Work:______________________

Birthdate:________________Email Address:____

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 that information below

Policy Holder's Name:_________________________________ID/SSN#___________________

Insurance Company:__________________________________Group#_____________________

Insurance Co. Address:____

Phone#__________________Policy Holder's Employer:_________________________________

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you:____

Phone:____________________________Relationship:__________________________________