Welcome to our office!

We look forward to getting to know you!

olentangy Orthodontics

Today's Date _____

About You

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name _____ Nickname/Preferred _____
Last First MI

Birthdate _____ Age _____ ☐ Male ☐ Female

SSN# _____

Home Ph _____ Cell Ph _____ Email _____

Work Ph _____ Ext _____

Employer _____

Residence Information

Home Address _____
Street

_____
City State Zip

Who may we thank for referring you to our office? _____ General Dentist _____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Account Responsibility Information

Name _____ SSN# _____
Last First MI

Birthdate _____ Relationship to Patient _____

Address (if different from patient's) _____ Home Ph _____
Street

_____ Cell Ph _____
City State Zip

Employer _____ Work Ph _____ Ext _____

Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Please provide a copy of your insurance card/coverage to us.

Office Use Only

Lifetime Max _____

Pays at % _____

Deductible _____

Amount used to date _____

Monthly/Quarterly/Other _____

% Initial Placement _____

Automatic ☐ Yes ☐ No

Emergency Contact Information

Name _____ Phone _____ Relation to patient _____

Payment of Services

Payment is due in full at time of treatment unless prior arrangements have been approved.
If this office accepts my insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to Dr. Edith Kang. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

_____
Signature Date

Continue to other side →

About Your Health

How would you describe your health? Good Fair Poor

Physician _____ Phone # _____ Date of Last Visit _____

Are you currently being treated by a physician? Yes No Reason: _____

_____

Please list all drugs/medications you are currently taking (including over the counter): _____

_____

For Women: Are you pregnant? Yes No Week # _____ Are you nursing? Yes No

Are you taking birth control medication? Yes No Medication _____

Do you have any allergies to foods and/or drugs/medications? Yes No

Please list _____

Allergy to (please circle) Latex Yes No Metals/Nickel Yes No Plastics Yes No

Please tell us if you have had any of the following (past and present)? (Please circle)

Y	N	Abnormal Bleeding	Y	N	ADD/ADHD	Y	N Alcohol/Drug Abuse
Y	N	Radiation Therapy	Y	N	Colitis	Y	N Difficulty Breathing
Y	N	Anemia	Y	N	Arthritis	Y	N Asthma
Y	N	Bisphosphonate Therapy	Y	N	Convulsions/Epilepsy	Y	N Birth Defects/Hereditary Problems
Y	N	Cancer/Chemotherapy	Y	N	Chest Pain/ Angina	Y	N Emphysema
Y	N	Fainting Spells	Y	N	Frequent Headaches	Y	N Glaucoma
Y	N	Heart Attack/Surgery	Y	N	Herpes/Fever Blisters	Y	N High Blood Pressure
Y	N	Kidney Problems	Y	N	Liver Problems	Y	N Low Blood Pressure
Y	N	Mitral Valve Prolapse	Y	N	Pacemaker	Y	N Psychiatric Problems
Y	N	Shingles	Y	N	Sinus Problems	Y	N Sickle Cell Disease/Traits
Y	N	Stroke	Y	N	Ulcers	Y	N Venereal Disease
Y	N	Congenital Heart Defect	Y	N	Diabetes	Y	N Handicaps/Disabilities
Y	N	Hearing Impairment	Y	N	Depression/Anxiety	Y	N Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia	Y	N Any Operations
Y	N	Hepatitis	Y	N	HIV+/AIDS	Y	N Artificial Bones/Joints/Valves
Y	N	Lupus	Y	N	Tuberculosis	Y	N Rheumatic/Scarlet Fever
Y	N	Delayed Growth	Y	N	Other(Please explain below)		

Please explain any “Y/Yes” answers _____

_____

Orthodontic/Dental Concerns

Have you been evaluated or had orthodontic treatment before? Y N

Please explain your reason/concern for an orthodontic evaluation: _____

Do you have or have you had any of the following:

Injuries to the face, mouth, teeth or chin? Y N

Pain/discomfort in your jaw joint (TMJ/TMD)? Y N

Speech problem? Y N

Problem or concern associated with previous dental work? Y N

Missing or extra permanent teeth? Y N

Do you still have wisdom teeth? Y N

What is your current dental health? Good Fair Poor

Are you happy with the way your smile looks or the way your teeth look? Y N

What would you change? _____

_____

Do you wish to address/discuss any issues privately (in the absence of people accompanying you today)? Y N

Sign Here

I have read and understand that the information that I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical health status. I will not hold my orthodontist or any member of the office staff responsible for any errors or omissions that I have made in completion of this form. I authorize the office staff to perform the necessary dental services I may need.

_____

Signature Date

Office Use Only

Doctor’s Review Signature: _____ Date: _____

Doctor’s Comments: _____

_____

_____