BIRMINGHAM ORTHODONTICS

MICHAEL F. MCCARTHY, DMD | ERIKA B. HARTMAN, DDS
CAREYBETH RIVERS, DMD

PATIENT INFORMATION

(Patients less than 21-years of age MUST have a Responsible Party)

Patient full name: ______________________ Nickname: ______________

Date of Birth	Age	Sex	Social Security #	Marital Status	Driver's License #/State
/ /				S M D W	

Best Phone #	Home Phone #	Cell Phone #	Work Phone #
( ) ____ - ______	( ) ____ - ______	( ) ____ - ______	( ) ____ - ______

Address: ______________________ City: ____________ State: ______ Zip: ______

Email address for notifications: ______________________ School: ______________

EMERGENCY CONTACT

Full Name: ______________________ Best Phone #: ( ) ______ - ________

Relationship to Patient: ______________________

Name of Patient's Dentist: ______________________

Did your dentist refer you to Birmingham Orthodontics for consultation? ○ Yes ○ No

Please list any other family members currently in treatment with us:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

How did you hear about our office? Patient Referral: ______________________

Other Source: ○ TV ○ Radio ○ Internet ○ Insurance ○ Yellow Pages ○ Coupon ○ School Program ○ Print Ad ○ Other: ______________

IS PATIENT COVERED BY ORTHODONTIC INSURANCE? ○ Yes ○ No * IF YES, PLEASE COMPLETE ATTACHED INSURANCE FORM *****

RESPONSIBLE PARTY INFORMATION

Responsible Party Full Name: ______________________ This is the person financially responsible for payments on this account.

Responsible Party Employer/City/State	Occupation	Time at Job (Years/Months)
		______ / ______

Relationship to Patient: ○ Self ○Parent ○ Grandparent ○ Aunt/Uncle ○ Legal Guardian ○ Other Relationship: ______________

Do you have legal custody of this patient? ○ Yes ○ No

If patient is responsible party, you do not need to fill out information twice. Please disregard next four lines.

Date of Birth	Age	Sex	Social Security #	Marital Status	Driver's License #/State
/ /				S M D W	

Best Phone #	Home Phone #	Cell Phone #	Work Phone #
( ) ____ - ______	( ) ____ - ______	( ) ____ - ______	( ) ____ - ______

Address: ______________________ City: ____________ State: ______ Zip: ______

Email address for notifications: ______________________

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

______________________ ______________

RESPONSIBLE PARTY SIGNATURE **DATE**

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MEDICAL HISTORY

PATIENT NAME: ______________________ **DATE OF BIRTH:** ____/____/____

Overall Medical Health: O Good O Fair O Poor
Are you under a Physician's care now? O Yes O No If YES, please explain: ______________
Primary Physician Name: ______________ Office Phone # ( ) ______________
WOMEN ONLY: Are you pregnant/trying to get pregnant? O Yes O No
Are you allergic to any of the following: O Latex O Penicillin O Codeine O Sulfa O Metal O Adhesives/Glue O Other:______________

Any history of the following: O NO KNOWN HEALTH PROBLEMS

O AIDS/HIV Positive
O Anemia
O Asthma
O Blood Pressure __ High __Low
O Blood Transfusion
O Bone Disorders/Osteoporosis
O Cancer/Chemotherapy/Radiation
O Cold Sores/Fever Blisters
O Convulsions/Epilepsy
O Diabetes
O Drug Addiction
O Fainting/Dizziness
O Free-bleeding/Hemophilia/Blood Thinners
O Heart Disease/Conditions
O Heart Murmur/Mitral Valve Prolapse
O Hepatitis A
O Hepatitis B or C
O Liver Disease
O Lung Disease/Emphysema
O Psychiatric/Emotional Care
O Sickle Cell Disease
O Sinus Trouble (Chronic)
O Thyroid/Endocrine Problems
O Venereal Disease

Any physical or special needs that we should be aware of? ______________
Any other medical problems we should be aware of? ______________
List any drugs or medications taken: ______________
Is pre-medication required for dental treatment? O Yes O No

DENTAL INFORMATION:

Primary Dentist Name: ______________ Date of Last Visit: ______________
Habits: (please circle) Thumb/Finger Sucking to age: ________ Lip Sucking/Biting to age: ________

Have you had previous treatment for:
Orthodontics? O Yes O No If YES, please explain: ______________
Periodontal Disease? O Yes O No If YES, please explain: ______________
TMJ? O Yes O No If YES, please explain: ______________

Have you ever had:

Speech problems?	O Yes	O No
Any injuries to face, head, mouth, or teeth?	O Yes	O No
Headaches, facial pain, or jaw joint problems?	O Yes	O No
Clicking or locking of jaws?	O Yes	O No
Bleeding gums?	O Yes	O No
Excessive fear or anxiety during dental treatment?	O Yes	O No
Tonsils/adenoids removed?	O Yes	O No
Any type of dental surgery (extractions, implants, jaw surgery)?	O Yes	O No

If YES, please explain: ______________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the dental office of any changes in medical status.

______________________ ______________

PATIENT SIGNATURE (or parent of minor) completing form **DATE**

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DATE: ________/________/________

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ________/________/________

INSURANCE INFORMATION

Do you have orthodontic coverage? O Yes O No

Policy Effective Date: ________/________/________

Name of Primary Insurance Company: ______________________________

Insurance Claims Mailing Address: ______________________________

Insurance Phone # for Providers: ______________ Group # ____________ ID # ______________

Policyholder's Name: ______________________________ Relationship to Patient: ______________

Policyholder's Date of Birth: ________/________/________ Policyholder's SSN: ______________

Policyholder's Address: ______________________________

Policyholder's Employer: ______________________________ Policyholder Phone # ______________

Policy Effective Date: ________/________/________

Name of Secondary Insurance Company: ______________________________

Insurance Claims Mailing Address: ______________________________

Insurance Phone # for Providers: ______________ Group # ____________ ID # ______________

Policyholder's Name: ______________________________ Relationship to Patient: ______________

Policyholder's Date of Birth: ________/________/________ Policyholder's SSN: ______________

Policyholder's Address: ______________________________

Policyholder's Employer: ______________________________ Policyholder Phone # ______________

Your orthodontic insurance claims are filed as a courtesy by our office. It is your responsibility to:

- **Personally confirm your orthodontic insurance benefits prior to treatment;**
- **Provide Birmingham Orthodontics with a copy of your current insurance card(s).**
- **Provide complete, accurate insurance information when treatment commences. If insurance claims filing information is incomplete, incorrect, or fails to process for any reason, your claims will not be filed by Birmingham Orthodontics.**

Birmingham Orthodontics is pleased to file insurance claims on your behalf and our goal is to help you receive all possible insurance benefits. Birmingham Orthodontics will not be responsible for non-payment of benefits. Your policy is a contract between the policyholder and the insurance company. If benefits are not paid, it is the responsibility of the policyholder to resolve coverage and claims issues directly with your insurance provider. We encourage you to contact us if your policy has not paid within 30 days of starting treatment.

______________________________ ______________

RESPONSIBLE PARTY SIGNATURE **DATE**