Knoll Orthodontics
Patient Registration / Medical History Form

Patient Information

Last name _____First name _____ Nickname _____

DOB ____/____/_____Age_____ Sex: F / M Status: Student / Single / Married / Divorced / Widowed / Domestic Partner
(Please Circle One)

Address _____ Town _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email _____

SSN _____ School / Employer name _____

General dentist name _____ Dentist phone _____

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

What is your main orthodontic concern? _____

Other family members seen by us _____

Responsible Party Information

Last name _____First name_____ Relationship to patient_____

DOB ____/____/_____ Sex: F / M Marital Status (circle one): Single / Married / Divorced / Widowed / Domestic Partner

Address _____ Town _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email _____

SSN _____ Employer name _____

Additional Contact Information

Last name _____First name_____ Relationship to patient _____

DOB ___/___/_____ Sex: F / M Marital Status (circle one): Single / Married / Divorced / Widowed / Domestic Partner

Address _____ Town _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email _____

SSN _____ Employer name _____

Insurance Information

Subscriber name _____ Subscriber DOB _____/_____/_____

Carrier name _____ SSN or ID # _____

Carrier address _____ Carrier phone _____

Group name _____ Group # _____

Secondary insurance _____

I hereby authorize the release of any information related to insurance claims. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I authorize payment of any insurance benefits to the office. I understand that I am fully responsible for payment of services rendered including any amounts not paid for by my insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I assign to knoll orthodontics all insurance benefits otherwise payable to me. I understand that I am responsible to report any changes to my insurance to the office.

Print name _____ Signature _____Date ___/___/____

Medical History

Physician name _____ Phone _____
Please list any allergies (to drugs, latex, metal, plastic, other) _____
Please list all medications and correlating diagnosis/condition _____
_____

Check all that apply:

- ☐ Abnormal bleeding / Hemophilia
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Handicaps / Disabilities
- ☐ Hearing impairment
- ☐ Heart murmur
- ☐ Hepatitis / Liver Issues
- ☐ HIV+ / Aids
- ☐ Kidney condition
- ☐ Neurological / Behavioral Issues
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Tuberculosis

If you checked any of the above or have another medical condition not listed above, please explain:

_____

_____

Dental History

Has patient ever had orthodontic treatment before? Yes No

Check all that apply:

- ☐ Loose, broken or missing fillings
- ☐ Chipped teeth
- ☐ Tooth sensitivity (to cold / hot / sweet / pressure)
- ☐ Bleeding gums / Periodontal disease
- ☐ Food collection between teeth
- ☐ Bad breath
- ☐ Sores or growths in mouth
- ☐ Clenching / Grinding
- ☐ Difficulty chewing or breathing
- ☐ Mouth breather
- ☐ Adenoids or tonsils removed
- ☐ Thumb habit
- ☐ Tongue thrust
- ☐ Lip sucking / biting
- ☐ Cheek / tongue biting
- ☐ Speech issues
- ☐ Jaw cysts / infection
- ☐ Jaw or TMJ clicking / popping / pain

If you checked any of the above or would like to provide additional information, please explain:

_____

_____

I understand the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my or my child's medical status. I consent to the examination by the doctor and, I authorize the staff to perform the necessary orthodontic services, including, but not limited to authorization to transmit patient information relating to my / my child's health or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Knoll Orthodontics health care operations. The patient information that may be emailed may include x-rays, health history, diagnosis, treatment and payment records. I understand that I do not have to sign this form; my treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form. If I do not sign this form, this office may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to 3rd parties myself. There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law. Knoll Orthodontics does not email such sensitive personal information as SSN, credit card number, mental health diagnosis, genetic information, alcohol / substance abuse, or positive HIV status unless the patient insists. I can tell you in writing to stop emailing my information, but this will not affect emails that have already been sent before receiving written instructions to stop.

_____ _____ _____/_____/_____

Print Name Signature Date