RIGALI AND WALDER ORTHODONTICS

Patient registration form and health questionnaire

Welcome and thank you for choosing Rigali and Walder Orthodontics. Please fill out this form completely in ink. If you have any questions or need assistance, please ask.

Date:_____

Patient Information

Name_____Birthdate_____Home phone_____

Address_____City_____State_____Zip_____

E-mail address (optional)_____Age_____Sex_____Student? (circle one) Y/ N_____

Spouse or Parent's Name_____

Patient's or Parent's employer_____Work phone_____

Person to contact in case of emergency_____Phone_____

Reason for seeking orthodontic treatment_____

Who referred you to our office?_____

General dentist's name_____

Date of last dental cleaning _____Were x-rays taken?_____

Responsible Party and Insurance Information

Name of person responsible for this account _____Relationship to patient_____

Address _____ City_____ State_____Zip _____

Home phone _____Work phone_____ SSN_____

Do you have dental insurance?_____ Does it cover orthodontic treatment?_____

Name of insured_____ Birth date_____

Name of insurance company_____

Group # _____Policy #_____

Insurance Company address_____City_____State _____ Zip_____

Medical and Dental History

1. Have you been under the care of a physician during the past 2 years?_____.
   If yes, for what reason?_____
2. Present medications (including non-prescription medications_____
   _____
3. Allergies: latex rubber? ___ metals? ___ list other allergies? _____
4. Do you use tobacco? ____ Do you use other controlled substances? ____
3. Have you ever had any periodontal or gum problems?_____

4. Are you now or have you ever been under the care of a periodontal specialist?_____

5. Have there been any injuries to the face, mouth, or teeth?_____

6. Have you had any head, neck or jaw injuries?_____

7. Have you had any TMJ or jaw problems such as clicking or pain?_____

8. Have you had orthodontic treatment in the past?_____

9. How would you rate your/your child's tolerance for discomfort (1 through 10 with 10 being the least able to tolerate any minor discomfort?_____

10. ***For women****: Are you pregnant or think you may be pregnant?_____*

11. ***For children and teens****:*
    a. *Has the patient reached puberty? Girls: menstruation? _____*
    b. *Boys: voice change?_____*
    c. *Has the patient ever sucked a thumb, or a finger?_____*
    d. *Does the patient have any speech problems?_____*
    e. *Patient's hobbies and interests:_____*

12. **Circle any of the following which you have had**:

Heart Disease	Rheumatic fever	Epilepsy	Thyroid problem
Heart Attack	High blood pressure	Kidney Condition	Glaucoma
Heart Murmur	Stroke	Asthma	Psychiatric treatment
Damaged Heart Valves	Blood disorder	Emphysema	HIV/Aids
Mitral valve prolapse	Anemia	Tuberculosis	Sexually transmitted disease
Artificial valves	Cancer/tumor	Fainting	Drug abuse
Chest Pain	Diabetes	Sinus problem	artificial joint
Hepatitis	Jaundice	Stomach trouble/ulcer	

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Rigali and Walder Orthodontics insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent if patient is a minor) ***date***

ACKNOWLEDGMENT OF RECEIPT OF THE PRIVACY NOTICE

I, _____, acknowledge that I have been provided with a copy of the HIPAA Rigali and Walder Orthodontics privacy notice.

_____

Signature of patient (or parent if patient is a minor) ***date***

Doctor's Comments:_____

_____

_____

_____

Signature of doctor *date*