Member American Association of Orthodontists

LEVENS ORTHODONTICS
Bringing smiles to life.

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PATIENT INFORMATION

Date_____ Patient's Name _____ Date of Birth _____ Age _____

Home Address _____
Street City State/Zip

Home Phone _____ Work Phone_____ Cell Phone _____

Patient's Physician _____ Patient's Dentist _____

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

RESPONSIBLE PARTY INFORMATION

Name _____ E-Mail _____ Phone _____

Home Address _____
Street City State/Zip

How long at this address? _____ Rent or Own?_____ Date of Birth _____ SSN _____

Employer _____ Occupation _____ # of years employed _____

SPOUSE or OTHER PARENT:

Name _____ E-Mail _____ Phone _____

Employer _____ Occupation _____ # of years employed _____

Date of Birth_____ SSN _____ Same Address as Above? ____ Yes ____ No

****PLEASE NOTIFY US IF THERE IS AN ADDITIONAL RESPONSIBLE PARTY NOT PRESENT****

DENTAL INSURANCE INFORMATION

Subscriber_____ Date of Birth _____ ID# _____

Insurance Company_____
Name Address Phone Number

Employer _____ Group Number _____

Person Responsible for This Account

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am financially responsible for all charges, regardless of insurance coverage.
I understand that where appropriate, credit bureau reports may be obtained. All information is kept confidential and is used only in providing our patients with best possible terms for free in-house financing options.

Patient/Parent/Guardian Signature_____ **Date** _____ **(continue on back)**

MEDICAL HISTORY

Does patient have or ever had:

Anemia	____ Yes____ No
Diabetes	____ Yes____ No
Hepatitis	____ Yes____ No
Abnormal Heart Condition	____ Yes____ No
Rheumatic Fever	____ Yes____ No
Abnormal Bleeding from a cut	____ Yes____ No
Heart Murmur	____ Yes____ No
COVID-19	____ Yes____ No

Does patient have allergies to:

Penicillin	____ Yes____ No
Local Anesthetic	____ Yes____ No

Other: _____

Dr.'s Notes: _____

_____

_____

Is patient under medical care now? ____ Yes____ No

If so, for what?_____

Is patient taking any medications now? ____ Yes____ No

Please list_____

Is patient taking any Bisphosphonates for osteoporosis (IE: Boniva, Fosamax, Actonel, Reclast)?____Yes____No

Please list_____

Does patient have any other medical conditions? ____ Yes____ No

Please list_____

<u>Dental Health</u>:

Date of last dental cleaning/exam _____

Any planned dental work? If yes, please explain: _____

Any jaw pain or other issues? If yes, please explain: _____

What would you like to change about your teeth/smile? _____

_____

SIBLINGS/CHILDREN:

_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth

Information given by (signature) _____ **Date**_____