Patient:

Patient Name_________________________ Age______ Gender M F Email ____

Mailing Address__________________________ City____________________ St________ Zip _____________

Employer_______________________________________ Occupation____

Birth Date __________________________ Phone Number _________________________________

Person responsible for payment of services________________________ Social Security #___________________________________

Who is your family dentist________________________ Person who referred you?____

DENTAL INSURANCE INFORMATION: PLEASE COMPLETE AS MUCH AS POSSIBLE:

Name of subscriber________________________________ Relationship to patient____

Birth date_________________ Social Security number _______________________ Work phone______________________________

Name of employer_____________________________ Insurance Company____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES COMPLETE THE FOLLOWING:

Name of subscriber________________________________ Relationship to patient____

Birth date__________________ Social Security number_______________________ Work phone_____________________________

Name of employer_________________________________ Insurance Company____

IF YOU HAVE INSURANCE PLEASE SIGN:
I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Peter Longo D.D.S, M.S., L.L.C

X____

Subscriber Signature Date

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating orthodontist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent of the law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X____

111 West 31st Street Kearney, NE 68847 308.224.2292 (T) 308.224.2293 (F)

Medical History

Physician ________________________________ Date of last visit ____

Please circle Yes or No (if yes fill in details)

Yes No Are you taking any medications? ____

Yes No Are you allergic to anything or any medication? ____

Yes No Do you have a history of a major illness? ____

Yes No Have you had any major operations? ____

Yes No Have you ever been involved in a serious accident? ____

Female patients only:

Yes No Are you pregnant?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorder	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____________________

Dental History

Dentist ____________________________________ Date of last visit ____

What concerns you most about your teeth?____

Yes No Have there been any injuries to face, mouth, or teeth? ____

Yes No Do your gums bleed with you brush? ____

Yes No Do you have any type of thumb or tongue habit? ____

Yes No Have you ever seen an orthodontist? If yes, who and when? ____

Yes No Are your jaw muscles or jaw joints ever sore when you awake in the morning?_________________________

Yes No Are you aware of your jaw clicking or popping? ____

Yes No Have you ever been told that you grind your teeth? ____

What is your attitude toward receiving orthodontic treatment? ____

Is this your first orthodontic consultation? ____

Appointments

The number of appointments required to complete your orthodontic treatment will depend on the complexity of the treatment. The majority of appointments are usually relatively short (15-20 min) and are scheduled at 4-6 week intervals. In addition to these short appointments, there are typically several longer appointments interspersed throughout the treatment for procedures such as putting braces on and taking braces off. As you might expect, many of our patients prefer afternoon appointments. **Although we will make every effort to accommodate your schedule, please be advised that some appointments will probably need to be during school/work hours.**

I have read and I understand the above statement regarding appointments, and I have truthfully answered all of the above questions regarding medical and dental history. I agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Longo to perform and complete orthodontic evaluation.

Signature: ____ Date: ____________________________