LONGO ORTHODONTICS

Patient:

Patient Name_____ Nickname_____ Age_____ Gender M F

Mailing Address_____ City_____ St_____ Zip _____

School & Grade _____ Favorite Activities_____

Birth Date _____ Phone Number _____

PARENTS/GUARDIANS INFORMATION (FILL IN BOTH SIDES COMPLETELY IF PARENTS LIVE AT DIFFERENT ADDRESSES):

Dad/Guardian's name_____ Mom/Guardian's name_____

Relationship to patient_____ Relationship to patient_____

Address_____ Address_____

City/St/zip_____ City/St/zip_____

Phone number_____ Phone number_____

Occupation_____ Occupation_____

Person responsible for payment of services_____ Social Security #_____

Dentist_____ Who referred you?_____ Email_____

DENTAL INSURANCE INFORMATION: PLEASE COMPLETE AS MUCH AS POSSIBLE:

Name of subscriber_____ Relationship to patient_____

Birth date of subscriber _____ 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_____

Signature Date

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

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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?

Yes No Has menstruation started?

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: _____