HOLMES PALMER ORTHODONTICS

Please fill out completely and return to front desk

Patients Full Name: _____
I prefer to be called: _____
Male _____ Female _____
Date of Birth: ____/_____/_____ S.S. #: _____-____-_____
Home Address: _____
Street Name and Number/Apt.

_____
City *State* *Zip*
Home Phone #: _(___)_____-_____Work Phone #: _(___)____-_____
What school does the patient attend? _____
How did you hear about our office? _____
Other family members seen by us: _____

Our office sends reminders for scheduled appointments, please check below for your consent: ☐ Automated Phone Call Home Phone #: _ (____)_____-_____
☐ Text Reminder Cell Phone #: _ (____)_____-_____
☐ E-Mail Reminder E-Mail Address: _____
(You can pick one or all three options, if you have any questions please see the front desk)

Name(s) of Parents/Guardians: _____ *Relationship*: **_____**
_____ *Relationship*: **_____**
(*Please provide all responsible parties' information*)
Person Financially Responsible for the Account: _____ Relationship**:_____**
Billing Address: _____
Street Name and Number/Apt.

_____
City *State* *Zip*
Home #: _ (___)____-_____
Work #: _ (___)____-_____ Spouse Work#:_(___)____-_____
Mobile #: _ (___)____-_____ Alternate #: _(___)____-_____
Employer:_____ Spouse Employer:_____

In the event of an emergency please list someone living outside your home that we may contact: _____ *Relationship:*_____
Home #: _(___)____-_____ Work #: _(___)____-_____

General Physician's Name: _____

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Telephone #: _(____)_____-_____

Primary Dental Insurance Information
Insurance Company: _____
Address: _____
Telephone #: _____ Ext. _____
Insured's Name: _____
Date of Birth: _____ S.S.#: _____ ID/Group #: _____
Employer: _____
Relationship to Patient: _____

Secondary Dental Insurance Information
Insurance Company: _____
Address: _____
Telephone #: _____ Ext. _____
Insured's Name: _____
Date of Birth: _____ S.S. #: _____ ID/Group #: _____
Employer: _____
Relationship to Patient: _____

Dental and Medical History

General Dentist: _____Date of Last Cleaning: _____/_____/_____
What are your main dental concerns?
_____
Have you been seen by an orthodontist before? _____
Dr.'s Name: _____ Date: _____/____/_____
Have you ever had an injury to your face or chin? _____
Are there any medical conditions present that would require patient to pre-medicate before appointments? _____
Are there any medical conditions present that would not allow Cephalometric or Panoramic X-Rays? _____
Do you generally breathe through your mouth or nose? _____
Are you currently under the care of a physician? _____
If so, please explain: _____
Are you taking any medications? If so, please list:
_____
Are you pregnant? Yes _____ No _____

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Are you allergic to latex? Yes _____ No _____
Are you allergic to nickel? Yes _____ No _____
Are there any other allergies or medical conditions that we should be aware of?
_____

Circle any of the following diseases or medical problems that you currently have or have had in the past.

Abnormal bleeding	**Heart Surgery**	**High/low blood pressure**
Anemia	**Hemophilia**	**Hepatitis**
Asthma	**HIV/AIDS**	**Kidney Problems**
Blood Transfusion	**Heart Murmur**	**Rheumatic Fever**
Cancer	**Shingles**	**Severe Headaches**
Sinus Problems	**Ulcers/Colitis**	**Frequent Headaches**

I understand that the information supplied on this form is correct to the best of my knowledge.
I authorize the orthodontic staff to perform any necessary dental services that I might need during diagnosis and treatment with my informed consent.

_____ _____/_____/_____
Signature Date

I understand that diagnostic records, photos, and the patient's name may be used for educational and promotional purposes.
I authorize,
Dr. W. Shane Holmes, Dr. Jack Palmer & Dr. Michael Signorelli
to review my records with my General Dentist, and/or Oral Surgeon.

_____ _____/_____/_____
Signature Date

Hobbies & Interests: _____

_____