

NEW PATIENT FORM

Today's Date _____

Name _____

Birth Date _____

Address _____

Home Phone _____ Cell # _____

City & State _____

Zip _____

Employer _____

Business No. _____

Insurance _____

SS# _____

Spouse's Name _____

Employer _____

Insurance _____ SS# _____

Business No. _____

Person Responsible For Account _____

Email Address _____

MEDICAL HISTORY

Physician _____ Current Medication _____

Have you lost or gained more than 10 pounds in the past year? _____

Have you ever had a blood transfusion? _____

Did you have a blood transfusion prior to 1985? _____

Do you have, or have you had, any of the following?

AIDS (HIV) _____ Scarlet Fever _____ Heart Problems _____

Emphysema _____ Tuberculosis _____ Bleeding Problems _____

Heart Murmur _____ Venereal Disease _____ Tonsils and/or Adenoids Removed _____

Hemophilia _____ Herpes _____ Nasal Problems or Allergies _____

Hepatitis A _____ Diabetes _____ Drug Allergies _____

Hepatitis B _____ Kidney Problems _____

Rheumatic Fever _____ Lung Problems _____

Other Health Or Developmental Problems _____

DENTAL HISTORY

Dentist _____ Last Visit _____

What concern brings you to our office? _____

Is this your 1st orthodontic exam? _____

Has there been an injury to the face, head or neck? _____

If yes, please explain _____

Do you hear popping or clicking noises in your jaws when you chew? _____

List names of family members in treatment at our office _____

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

I understand that due to the nature and length of much orthodontic treatment, payment is often arranged over a period of time. Therefore, I authorize Dr. Diers' office to obtain a credit report from the Credit Bureau of Cincinnati.

DATE _____

SIGNATURE _____