Cumberland Pediatric Dentistry and Orthodontics

We would like to welcome you to our office.

All information is confidential. Thank you.

Date:_________ Patient's Full Name: ______________________________DOB: ____________
Age: _________ Male or Female Social Security #: ______________________________
Home Address: ____
City: ________________State: _______Zip: _________Email Address:___________________
We require that we have at least 2 phone numbers for contact purposes
Hm. #: ____________________ Cell. #;____________________Wk. #;
____

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

IF UNDER 18

School:________________________ Grade: _____ Hobbies:___________________________
Siblings Name: ____________________________________Has any family member had braces before? If so, who?____

Responsible Party

First Name: _________________ Last Name: ________________MI: ____ Marital Status _____
SS# _______________________ DOB ____________ Relation to Pt.____________________
Home Address: ____
How long at this address? ____ Home phone: _______________Work Phone: ______________
Previous Address (if less than 3 years): ____

Additional Responsible Information

First Name: _________________Last Name: ________________MI: ____ Marital Status _____
SS# _______________________ DOB ____________ Relation to Pt.____________________
Home Address: ____
How long at this address? ____ Home phone: _______________Work Phone: ______________
Previous Address (if less than 3 years): ____

For your convenience we offer the following methods of payment. Please circle preferred option: Care Credit Debit or Credit Card Cash

INSURANCE POLICY HOLDER INFORMATION

Name of Insured ___________________________DOB: ___________SS# _________________
Primary Ins. Co. ______________ ID# _______________________Group # ______________
Insurance Co. Address / Ph. # ____
Employer Name ______________________________ How long Employed? ___________
Employer Address/Ph. # ____
Relation to Patient _____________________________________

Name of Insured ___________________________DOB: ___________SS# _________________
Secondary Ins. ______________ ID# _______________________Group # ______________
Insurance Co. Address / Ph. # ____
Employer Name ______________________________ How long Employed? ___________
Employer Address/Ph. # ____

EMERGENCY INFORMATION

Who may we contact in the event of an Emergency? ____________________________________

Hm. #: ______________________ Cl#. ______________________ Wk. # ______________
Relation to Patient ____

DENTAL/MEDICAL HISTORY

Dentist Name: ______________________ Phone:____________ Last cleaning?____ _____
Physician Name: ____________________ Phone: ____________ last visit? ___ __________
Has an orthodontist previously been consulted? ____ If so, when? ______________________
What concerns would you like Orthodontics to accomplish?_____________________________
Is the patient currently under a physician's care? _____ No ______Yes
If yes, for what reason?___________________________________
Have the tonsils and adenoids been removed? ___ __ No _____ Yes
Has the patient ever sucked a thumb or finger? ___ __ No _____ Yes
Until what age? _______________________________________
Is the patient currently taking any drugs/medications? _____ No _____Yes
If yes please list: _____________________________________
Does the patient have any allergies? ______No _____ Yes
If yes please list: _____________________________________
Has there ever been an adverse reaction to latex or nickel? ______ No _____ Yes
Does the patient need antibiotics before seeing the dentist? ______ No _____ Yes

Please circle any of the following conditions that the patient has had or now has:

Congenital Heart Lesions	Anemia	Epilepsy/Seizures	Jaw/Facial injuries
Heart Murmur	HIV/AIDS	Fainting Spells	Dental/Tooth Injuries
Rheumatic Fever	Hepatitis	Asthma	Frequent Headaches
Tuberculosis	Kidney Problems	Mouth Breathing	Clenching/grinding of teeth
Persistent Cough	Liver Problems	Speech Problems	Ringing in the ears
Abnormal Bleeding	Stomach ulcers	Canker Sores	Sinus Trouble
High/Low Blood Pressure	Mental Disorders	Jaw Locking	Smoke/Chew tobacco
Cancer	Heart Disease	Glaucoma	Arthritis
Allergies	Thyroid problem	Diabetes	Pregnant Now?
Sore Facial Muscles			

Please explain conditions from above as needed: ____
____

Do you have any medical or dental problems not listed above? ______ No _____ Yes
Please explain: ____

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Orthodontist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such Orthodontic care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the Orthodontist insurance payments otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby give Dr. Ewing and Team permission to confirm appointments using the phone number(s) I have provided, to include leaving messages

____Date______________________
Signature Patient/Parent/Guardian
I verbally reviewed the medical/dental information above with the Patient/Parent/Guardian.
Signed: ____________________________________ Date: ____________________

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: State / Zip: Pager: ______

Home Phone: ______ Work Phone: ______ Ext: Cellular: ______

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ______ Age: ______ Soc. Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg.: ______

Section 3

Referred By: ______

Previous Dentist: ______

Emergency Contact: ______

Emergency Contact #: ______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____________

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

Comments: ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE __________