Appointment Date ______________ | office use

Patient Name ______________ Nickname ______________ ☐ Male ☐ Female Age ______ Date of Birth ______________

Relatives who have visited our office: ______________

Patient Mailing Address ______________ **Home Phone #** (______________

Street City State Zip

If Patient is a child Parent/Guardian 1 ______________ Relationship: ______________ Social Security ______________ Work Phone (______________

Address ______________ Cell Phone: (______________

Street City State Zip **Employer**

Parent/Guardian 2 ______________ Relationship: ______________ Social Security ______________ Work Phone (______________

Address ______________ Cell Phone (______________

Street City State Zip **Employer**

I request Appointment Confirmation Via: TEXT ______________ Carrier: ______________ And Or ______________

Cell Phone Number (ie. Verizon, AT&T etc.) E-Mail Address

DENTIST Information ______________ Referred By ______________

Name Street City State Phone Number

Primary Dental/Ortho Insurance Co. ______________

Co. Name Address Phone # Group # ID # **Subscriber Name & D.O B.**

Secondary Dental/Ortho Insurance Co. ______________

Co. Name Address Phone # Group # ID # **Subscriber Name & D.O B.**

MEDICAID I.D. # ______________

Reason for Today's Visit ______________ Patient's Last Dental Exam ______________ Last X-Rays ______________

Please Circle or Check if you have or have had any of the following:

Aids or HIV Cancer Hepatitis Heart Murmur Rheumatic Fever Psychiatric Care Women: Are you pregnant? ______________

Blood Disease Diabetes Jaw Pain Liver Disease Respiratory Disease High Blood Pressure Allergies to Medication or Metals ______________

General Health ______________ Any major operations ______________ Current Medical Treatment: ______________

Patient's Physician ______________ Current Medication: ______________

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

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.

I have received a copy of Watterworth Orthodontics, PA Privacy Disclosure in accordance with HIPPA regulations. Online at www.seacoastortho.com/treatment-info/privacy-ststement

Signature ______________ Date ______________ **Brad Watterworth, DMD**