HOLT ORTHODONTICS ACQUAINTANCE FORM

PATIENT INFORMATION

Patient full name: _____
Address: _____
City: _____, CA Zip: _____
Telephone: _____
Date of Birth: _____

Dentist: _____
Referred by: _____
Hobbies & Interests: _____
Patient likes to be called: _____
If a student, School and Grade: _____

1st RESPONSIBLE PARTY INFORMATION:

Name:_____
Relationship to Patient:_____
❑Self ❑Mother ❑Father ❑Other_____
Responsible Party Marital Status:
❑Single ❑Married /Spouse Name _____
❑ Divorced ❑Widowed
Address:_____
_____
Home Telephone:_____
Work Telephone:_____
Cell Telephone:_____
Email:_____
Employer:_____
Occupation:_____

INSURANCE

Dental Insurance Carrier:_____
Subscriber Name:_____
SSN or ID Number:_____
Subscriber Birthdate:_____
Group#_____

2nd RESPONSIBLE PARTY (IF APPLICABLE):*

Name:_____
Relationship to Patient:_____
❑Self ❑Mother ❑Father ❑Other_____
Responsible Party Marital Status:
❑Single ❑Married /Spouse Name _____
❑ Divorced ❑Widowed
Address:_____
_____
Home Telephone:_____
Work Telephone:_____
Cell Telephone:_____
Email:_____
Employer:_____
Occupation:_____

INSURANCE

Dental Insurance Carrier:_____
Subscriber Name:_____
SSN or ID Number:_____
Subscriber Birthdate:_____
Group#_____

***If there are 2 responsible parties** (in different households):
Is custody shared? ❑ No ❑ Yes @ _____/_____%
With whom does the patient primarily reside? _____If there is a court order regarding Insurance/please explain:_____

MEDICAL HISTORY: Please circle yes or no and write any details for the doctor.

Yes/No Is patient in good health? | Yes/No Has he/she been treated by a physician in the last 2 years?
Yes/No Is he/she taking any medications now? If yes, please list:_____
Yes/No Does he/she suffer from any allergies: If yes, please list:_____

Has patient ever had any of the following? **Please circle yes or no.**

Yes/No Diabetes	Yes/No Asthma	Yes/No Prolonged Bleeding	Yes/No Rheumatic fever
Yes/No Arthritis	Yes/No Nervous Disorders	Yes/No Heart Murmur	Yes/No Tonsillitis
Yes/No Hepatitis	Yes/No Epilepsy	Yes/No Brain Injury	Yes/No Anemia
Yes/No Tuberculosis	Yes/No Kidney Disease	Yes/No Heart Trouble	Other: _____
Yes/No Autism	Yes/No Sensory disorder	Yes/No Learning disability	

(This information will aid in our office communication and instructions during treatment)

DENTAL HISTORY: Please circle yes or no if there is a history of any of the following:

Yes/No Jaw joint popping	Yes/No Noise/pain in jaw or ears	Yes/No Uncomfortable Bite
Yes/No Clenching/grinding teeth	Yes/No Mouth breather	Yes/No Frequent headaches
Yes/No Injury to head/neck/jaw	Yes/No Missing teeth	Yes/No Extra teeth
Yes/No Previously Treated TMJ	Yes/No Sucked thumb/fingers	Year stopped _____

Yes/No Have others in the family had a similar condition or received orthodontic treatment?
Yes/No Has patient had any previous orthodontic treatment or consultations?
Names and ages of brothers and sisters: _____
When did patient last visit the Dentist? _____ Dentist Name: _____
Any specific problem you would like us to fix? _____

I, _____ (print name) attest that the above information is true and accurate and authorize (if applicable) Dr. Holt's office to bill insurance for treatment. I acknowledge receipt of the office's Notice of Privacy Practices. It is also available at www.BracesByHolt.com or posted in the office.

Signed: _____Relationship to patient:_____ Date:_____

Examining Doctor's Signature:_____Exam Date_____