Please complete all pages of this form

Nickname: _____ Male Female

Child's Name: _____
First Middle Last

Address: _____
Street City State Zip

Phone: _____ Childs School: _____

Birthdate: _____ Hobbies / Sports: _____

Whom May We Thank For Referring You!

Please Circle

Facebook Instagram Internet Search Friend _____ Family Dentist _____
Name Name

Parents Marital Status: Married Divorced Single Widow

Father's Name: _____
First Middle Last

Father's Email: _____

Address: _____
Street City State Zip

Phone: _____
Home Cell Work

Birthdate: _____ Social Security: _____ Employer: _____

Mother's Name: _____
First Middle Last

Mother's Email: _____

Address: _____
Street City State Zip

Phone: _____
Home Cell Work

Birthdate: _____ Social Security: _____ Employer: _____

Insurance Information

Primary Orthodontic Insurance: _____

Address: _____
Street City State Zip

Insurance Phone: _____ Group # _____ ID # _____

Policy Owners Name: _____ Birthdate: _____ Relationship to Patient: _____

Policy Owners Employer: _____ Lifetime Maximum: _____

Secondary Orthodontic Insurance: _____

Address: _____
Street City State Zip

Insurance Phone: _____ Group # _____ ID # _____

Policy Owners Name: _____ Birthdate: _____ Relationship to Patient: _____

Policy Owners Employer: _____ Lifetime Maximum: _____

Health History

Patients Name: _____
First Middle Last

Family Dentist: _____ Clinic: _____

Last Check-Up or Cleaning within 6 Months? YES NO

Physician Dentist: _____ Clinic: _____

Are you currently taking any prescription/ over-the counter drugs? YES NO

Please List Each One: _____

Have you ever experienced any of the following problems?
Circle YES

Headaches **Fainting**
Teeth Grinding **Vomiting**
Gagging **TMJ**

Are you allergic to any of the following?
Circle YES

Latex
Aspirin
Ibuprofen
Nickel

Diagnosed or treated
Circle YES

Arthritis **Asthma** **Seizures**
Hearing Impaired **Head Trauma**
Diabetes **Anemia** **Hepatitis**
Teeth Trauma **Pregnancy**
HIV/Aids **Blood Pressure**
*** **Joint Replacement / Implants**
*** **Rheumatic Fever**
*** **Heart Murmur**

*** Does the patient require antibiotic pre-medication for dental treatment? YES NO

65 Josh Hall Road Blue Ridge GA 30513 706-633-4824

Insurance assignment and release-I, the undersigned assign directly to Tipton Orthodontics all insurance benefits, otherwise payable to me for services rendered. I also hereby authorize Blue Ridge Orthodontics to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Financial Responsibility- I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware of the financial policies regarding patient services, payment and insurance assignment if applicable.

In accordance with the federal government HIPAA rules, please sign below to acknowledge you have received our notice of Privacy Practices; it will in no way affect the care you receive at Blue Ridge Orthodontics.

X _____ DATE: _____