

# MOSHIRI ORTHODONTICS

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## Patient Information

Name \_\_\_\_\_  
LAST FIRST MIDDLE

Email (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Home Address \_\_\_\_\_  
STREET CITY/STATE ZIP

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_

School/Employer \_\_\_\_\_

If patient is a minor, give parent or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Family Dentist \_\_\_\_\_ Physician \_\_\_\_\_

## Responsible Party Information

(this portion must be filled out completely)

Name \_\_\_\_\_ S M D W  
LAST FIRST MIDDLE Marital Status

Email (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Home Address \_\_\_\_\_  
STREET CITY/STATE ZIP

Mailing Address \_\_\_\_\_  
STREET CITY/STATE ZIP

How long at this address? \_\_\_\_\_ Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

## Responsible Party Spouse Information

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Email (Home) \_\_\_\_\_ Work \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

## Primary Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's SSN No. \_\_\_\_\_  
Email (Home) \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

## Secondary Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's SSN No. \_\_\_\_\_  
Email (Home) \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_ Updates (dates & initials) \_\_\_\_\_

## Emergency Information - Not Living with Patient or Responsible Party

Name of Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_ Date of Last visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (if Yes, please fill in details)

Yes	No	Are you taking any medication(s)? List _____
Yes	No	Is antibiotic required prior to dental work? _____
Yes	No	Are you allergic to any medication (s)? List _____
Yes	No	Do you have a history of a major illness? _____
Yes	No	Are you currently under the care of a physician for a specific illness? _____
Yes	No	Have you had any major operations? _____
Yes	No	Have you ever been involved in a serious accident? _____

Check any of the following for which you have been treated?

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Colds                   | <input type="checkbox"/> Heart Problems/Heart Murmur | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Herpes                         |
| <input type="checkbox"/> Sore Throats            | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Immune Deficiency/HIV/Aids     |
| <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Fainting/Dizziness         | <input type="checkbox"/> Mental/Psychological Disorders |
| <input type="checkbox"/> Ear Infections/Tubes    | <input type="checkbox"/> Endocrine Problems          | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Nervous Disorders              |
| <input type="checkbox"/> Allergies/Latex/Others  | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> ADD/ADHD                       |
| <input type="checkbox"/> Asthma/Hay Fever        | <input type="checkbox"/> Thyroid Problems            | <input type="checkbox"/> Kidney Problems            | <input type="checkbox"/> Tumor/Cancer                   |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Bone Disorders              | <input type="checkbox"/> Hepatitis/Liver Problems   | <input type="checkbox"/> Radiation/Chemotherapy         |

# Dental History

Dentist \_\_\_\_\_ Date of Last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Goals desired in seeking orthodontic care? \_\_\_\_\_

Please circle Yes or No (if Yes, please fill in details)

Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_

Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_

Yes No Have any other family members been treated in this office?  
How did they feel about the result? \_\_\_\_\_

Yes No Are you presently in any dental pain? Explain \_\_\_\_\_

Yes No Is any part of your mouth sensitive to temperature or pressure? Explain \_\_\_\_\_

Yes No Do your gums bleed when you brush? Date of last cleaning appointment with general dentist \_\_\_\_\_

Yes No Are you a mouth breather? \_\_\_\_\_

Yes No Have your tonsils and adenoids been removed? What age? \_\_\_\_\_

Yes No Have you ever had any type of thumb sucking/pacifier use/nail biting or tongue habit? Until what age? \_\_\_\_\_

Yes No Do you have any speech problems? \_\_\_\_\_

Yes No Have there been any injuries to your face, mouth or teeth? Explain \_\_\_\_\_

Yes No Have there been any falling accidents or sport injuries? Explain \_\_\_\_\_

Yes No Have you been involved in any automobile accidents or received whiplash? \_\_\_\_\_

Yes No Have you ever had sprained or broken bones? Explain \_\_\_\_\_

Yes No Do you get headaches? How many times per week? \_\_\_\_\_

Yes No Do you have facial or orbital pain? \_\_\_\_\_

Yes No Do you have jaw pain? Which side? \_\_\_\_\_

Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? \_\_\_\_\_

Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_

Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_

Yes No Do you have neck/shoulder/lower back pain? \_\_\_\_\_

Yes No Have you ever experienced chronic ringing or a feeling of fullness in your ears? \_\_\_\_\_

Yes No Do you have numbness in your fingers and/or toes? \_\_\_\_\_

Yes No Do you have clicking or popping of your jaw joints? Which? \_\_\_\_\_

Yes No Have you ever experienced open and/or closed lock? Explain \_\_\_\_\_

Yes No Have you ever had jaw and/or joint surgery? When? \_\_\_\_\_

Yes No Are you aware that some appointments will be during school/work hours? \_\_\_\_\_

If the patient is under age 16, height of parents. Mom \_\_\_\_\_ Dad \_\_\_\_\_ Patient \_\_\_\_\_

Please list some hobbies or interests \_\_\_\_\_

Female Patients only:

Yes No Are you pregnant? Due Date \_\_\_\_\_

If patient is under the age of 18, age menstruation began \_\_\_\_\_

Male patients only:

If patient is under the age of 18, age voice changed \_\_\_\_\_

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## Insurance Eligibility and Benefit Determination

### Patient

Name \_\_\_\_\_ Patient No. \_\_\_\_\_

### Primary Coverage

(this portion must be filled out completely)

Insured's Name \_\_\_\_\_ Insured's SS No. \_\_\_\_\_

Employer Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer City/State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's relationship to insured \_\_\_\_\_ Self \_\_\_\_\_ Child \_\_\_\_\_ Spouse \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Group No. \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Secondary Coverage

Insured's Name \_\_\_\_\_ Insured's SS No. \_\_\_\_\_

Employer Name \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer City/State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's relationship to insured \_\_\_\_\_ Self \_\_\_\_\_ Child \_\_\_\_\_ Spouse \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Group No. \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

- Please present your insurance card so that copies can be made.
- The benefits obtained from your carrier may be subject to change.

**For Office Use Only**

Self       Spouse       Family

Ortho Maximum \_\_\_\_\_ Deductible \_\_\_\_\_ Payment \_\_\_\_\_

Effective Date \_\_\_\_\_ Waiting Period \_\_\_\_\_ Age Limit \_\_\_\_\_

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Prior benefits used \_\_\_\_\_ Remaining benefit amount \_\_\_\_\_

How is claim paid       Monthly       Quarterly       Other \_\_\_\_\_

Continuation treatment forms       Not required       Required

Mail to \_\_\_\_\_ Verified by \_\_\_\_\_

\_\_\_\_\_ Contact Person \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Group No. \_\_\_\_\_ Payor ID No. \_\_\_\_\_

Dup Benefit?       Yes       No

**For Office Use Only**

Self       Spouse       Family

Ortho Maximum \_\_\_\_\_ Deductible \_\_\_\_\_ Payment \_\_\_\_\_

Effective Date \_\_\_\_\_ Waiting Period \_\_\_\_\_ Age Limit \_\_\_\_\_

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Prior benefits used \_\_\_\_\_ Remaining benefit amount \_\_\_\_\_

How is claim paid       Monthly       Quarterly       Other \_\_\_\_\_

Continuation treatment forms       Not required       Required

Mail to \_\_\_\_\_ Verified by \_\_\_\_\_

\_\_\_\_\_ Contact Person \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Group No. \_\_\_\_\_ Payor ID No. \_\_\_\_\_

Dup Benefit?       Yes       No