2401 Ring Road
Heartland Professional Building
Elizabethtown, KY 42701
(270) 765-6502

DuPLESSIS ORTHODONTICS

618 Bypass Road
Brandenburg, KY 40108
(270) 422-KIDS (5437)

American Association of Orthodontists
My Life. My Smile. My Orthodontist.™

Welcome

Patient Information

Today's Date _____

Patient Name _____ (*Last* *First* *Middle*) **SSN** _____

Address _____ **City** _____ **St** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____ **Birth Date** _____ **Age** ___ **Sex** ☐**M** ☐**F**

Email Address _____

Patient School or Employed By _____ **Grade In School** _____

Whom may we call in case of emergency? (not living in the home) _____ **Phone** _____

Favorite Activities/Sports _____

Responsible Party

Father's Name _____ **SSN** _____ **Birthdate** _____ **Phone** _____

Employed By _____ **Father's Work Phone #** _____

Mother's Name _____ **SSN** _____ **Birthdate** _____ **Phone** _____

Employed By _____ **Mother's Work Phone #** _____

If divorce is involved, who is the Custodial Parent? _____

Address _____ **City** _____ **St** _____ **Zip** _____

Social Security Number _____

Primary Insurance Information

Do you have orthodontic insurance coverage ☐**No** ☐**Yes**

Insurance Company _____ **SSN** _____ **Phone # For Dental Benefits** _____

Subscriber Name _____ **Birth Date** _____

Group # _____ **Subscriber # or ID #** _____

Address (if different from Patient's) _____ **City** _____ **St** _____ **Zip** _____

Subscriber Employed By _____ **Relation to Patient** _____ **Employer Phone** _____

Please complete reverse side.

TODAY'S DATE _____ PATIENT NAME _____ BIRTHDATE_____

SECONDARY INSURANCE INFORMATION

Is Patient covered by additional insurance ☐Yes ☐No
Insurance Company _____ Phone # For Dental Benefits _____
Subscriber Name_____ Subscriber # or ID # _____ SSN _____
Relation to Patient_____ Birthdate _____

DENTAL HISTORY

Whom may we thank for referring you to us? _____
Family Dentist _____ Date of Last Visit _____
Any major falls or accidents (particularly in the area of the face) _____
Any thumb or finger sucking habits _____ Other_____
Has the patient been examined by an orthodontist before?_____ When_____
Has DuPlessis Orthodontics previously treated any siblings? If so, sibling's name _____
What would you like to change about your smile? _____

MEDICAL HISTORY

LATEX ALLERGY ☐ Yes ☐ No
Physician's Name _____Date of Last Visit_____
Have you had any serious illnesses or operations _____Yes _____No If Yes, describe _____
Have you ever had a blood transfusion? _____Yes _____No If Yes, give approximate dates _____
(Women) Are you Pregnant? _____Yes _____No Nursing? _____Yes _____No Taking birth control pills _____Yes _____No
Check (√) if you have or have had any of the following:

☐ ADHD	☐ Chemical Dependency	☐ Heart Problems	☐ Mitral Valve Prolapse	☐ **Stroke**
☐ Aids	☐ Chemotherapy	Describe_____	☐ Nervous Problems	☐ **Substance Abuse**
☐ Alcohol Use	☐ Circulatory Problems	☐ Hemophilia	☐ Nicotine	☐ **Swelling of Feet or Ankles**
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hepatitis	☐ No Known Allergies	☐ **Thyroid Problems**
☐ Artificial Heart Valves	☐ Cough, Persistent	☐ High Blood Pressure	☐ Non Verbal	☐ **Tobacco Habit**
☐ Artificial Joints	☐ Cough Up Blood	☐ HIV Positive	☐ Pacemaker	☐ **Tuberculosis**
☐ Asberger Syndrome	☐ Diabetes	☐ Jaw Pain	☐ Psychiatric Care	☐ **Ulcer**
☐ Asthma	☐ Down Syndrome	☐ Kidney Disease	☐ Radiation Treatment	☐ **Veneral Disease**
☐ Back Problems	☐ Epilepsy	☐ Liver Disease	☐ Respiratory Disease	☐ **Other**
☐ Behavorial Issues	☐ Fainting	☐ Mental Health Disorder	☐ Rheumatic Fever	**Describe**_____
Describe_____	☐ Glaucoma	Describe_____	☐ Scarlet Fever	
☐ Blood Disease	☐ Headaches	☐ Metal Allergy	☐ Shortness of Breath	
☐ Cancer	☐ Heart Murmur	Describe_____	☐ Skin Rash	

Medications: List all medications you are currently taking _____
_____
Allergies: List any and all allergies you may have _____
_____

AUTHORIZATION AND CONSENT FOR SERVICES

I consent to treatment and authorize the release of any information including diagnosis, records of treatment and examination rendered to myself, third party payers and/or other health and dental practioners. I further authorize the dentist to file appeals or reconsiderations of denied services or pre-authorizations on my behalf. I understand these communications may take place electronically.

I authorize my insurance company to pay to the Dentist or Dental Group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand I will inform your office of any changes in my insurance coverage within 30 days.

I authorize the Dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that a credit reporting agency may be contacted.

Signature _____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.