



Welcome

Patient Information • Adult

Name _____ Age _____ Birth Date _____
First Middle Last

Nickname (if preferred) _____ Male Female Email Address _____

Home Phone # _____ Cell Phone # _____ SS # _____

Home Address _____
Street City State Zip

Employer _____ Employer's Address _____
Street City State Zip

Occupation _____ How Long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO • If YES, Name _____
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? _____

Have you visited an orthodontist before? YES NO • If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? YES NO

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to Kelly M Giannetti, DMD, MPH, MS. I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____

Continued on back

Orthodontic Specialist
Kelly M Giannetti
— DMD, MPH, MS, APC —

Dental and Medical History

Are you currently under the care of a physician? YES NO • If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? YES NO • If YES, please describe _____

Any sensitivities or allergies? YES NO • If YES, please list _____

Currently taking any medications? YES NO • If YES, please list _____ Amount/Dose _____

Have you been treated for any of the following?

- | | | | | |
|---------------------------------|--------------------------------------|--------------------------------|---|---|
| <input type="radio"/> Arthritis | <input type="radio"/> Blood Disorder | <input type="radio"/> Diabetes | <input type="radio"/> Heart Condition | <input type="radio"/> Nervous Disorders |
| <input type="radio"/> Asthma | <input type="radio"/> Cancer | <input type="radio"/> Epilepsy | <input type="radio"/> High Blood Pressure | <input type="radio"/> Tuberculosis |

Do you require antibiotics before dental treatment? YES NO • If YES, explain _____

Have there been injuries to your face, mouth or chin? YES NO

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD)? YES NO

Do/Did you have any of the following habits?

- | | | |
|---|--|---|
| <input type="radio"/> Grinding Teeth | <input type="radio"/> Finger/Thumb Sucking | <input type="radio"/> Tongue Thrusting |
| <input type="radio"/> Chronic Mouth Breathing | <input type="radio"/> Speech Problems | <input type="radio"/> Chewing/Eating Problems |

Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name _____ Insurance Company Phone # _____

Insurance Company Address _____ Street _____ City _____ State _____ Zip _____ Group or plan # _____

Insured's Name _____ First _____ Middle _____ Last _____ Insured's Birth Date _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____ Street _____ City _____ State _____ Zip _____

Secondary

Insurance Company Name _____ Insurance Company Phone # _____

Insurance Company Address _____ Street _____ City _____ State _____ Zip _____ Group or plan # _____

Insured's Name _____ First _____ Middle _____ Last _____ Insured's Birth Date _____

Relationship _____ Insured's SS # _____

Insured's Employer _____ Employer's Address _____ Street _____ City _____ State _____ Zip _____