



TINGEY Orthodontics

Welcome To TINGEY orthodontics



Please take a moment to tell us about yourself

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PATIENT INFORMATION

Name _____ Date _____
 Nickname _____
 Address _____
 City _____ State _____ Zip _____
 Birth date _____ Age _____ M F

PHONE NUMBERS

Home _____ Cell _____
 Work _____ Ext _____
 SSN _____ Marital Status S M D
 Email _____
 Employer _____
 General Dentist _____
 Incase of an Emergency Contact _____
 Phone _____ Relation _____

INSURANCE INFORMATION

Yes No

We can make a copy of the card

Primary Insurance Company _____
 Insured Name _____
 Contact # _____ Group # _____
 Subscriber # _____ Employer _____
 Coverage Amount _____ % up to _____ max _____ deduct _____
 Relationship to patient _____
Secondary Insurance Company _____
 Insured Name _____
 Contact # _____ Group # _____
 Subscriber # _____ Employer _____
 Coverage Amount _____ % up to _____ max _____ deduct _____
 Relationship to patient _____

DO YOU HAVE A FLEX PLAN THROUGH WORK Yes No

REFERRAL

WHO MAY WE THANK FOR REFERRING YOU?

- Dentist _____
- Friend /Family _____
- Yellow pages _____
- Internet _____
- Other _____

SPOUSE'S INFORMATION

Name _____ DOB _____
 Work Number _____
 Employer _____
 Social Security Number _____

MEDICAL HISTORY

Please answer yes or no to indicate the following conditions:

- | | |
|---------------------------|---------------------------------|
| Yes No Heart Murmur | Yes No Asthma |
| Yes No Rheumatic Fever | Yes No Tuberculosis |
| Yes No Prolonged Bleeding | Yes No Cancer |
| Yes No Anemia | Yes No Growth Disorders |
| Yes No Kidney Disease | Yes No Disabilities |
| Yes No Liver Disease | Yes No Emotional Problems |
| Yes No Diabetes | Yes No Fever Blisters |
| Yes No Hepatitis | Yes No Allergies to Latex/Metal |
| Yes No Epilepsy | Yes No Allergies to Medication |
| Yes No Fainting | _____ |

- Have you experienced any health problems? Yes No
 Any major changes in your health recently? Yes No
 Are you currently under physician care? Yes No
 Are you currently taking any medications? Yes No
 Have you been in a risk group for AIDS? Yes No
 Any conditions that you feel we should know about? _____

What concerns has your dentist expressed about you bite?

- Yes No Wear or fracture of teeth
 Yes No Bone/Gum loss
 Yes No Difficulty with cleaning as a result of crowding
 Yes No Other _____

Please indicate history of:

- Yes No Clenching Teeth Yes No Sleep Apnea
 Yes No Grinding Teeth Yes No Frequent Headaches
 Yes No Jaw Joint Problems Yes No Speech Problems

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that the information that I have given today is complete and accurate. I understand that it is my responsibility to inform the office of any changes.

Signature _____

Date _____