



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

Home Phone Number _____

Email _____

Student/School _____

Favorite Sports or Hobbies _____

Incase of an Emergency Contact _____

Phone _____ Relation _____

General Dentist _____

INSURANCE INFORMATION

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 _____
- Yellow pages _____
- Internet _____
- Other _____

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			

Does your child have any health issues we should know about? Yes No

Have your child's tonsils or adenoids been removed? Yes No

Has your child been in a risk group for AIDS? Yes No

PARENT INFORMATION

Mother's Information

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Hm Phone _____ Cell Phone _____

Employer _____ Phone _____

Father's Information

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Hm Phone _____ Cell Phone _____

Employer _____ Phone _____

The parent or Guardian who accompanies the child is responsible for payment.

Growth Information: Because growth can be an important factor in orthodontic treatment planning, your answers to the following are needed to aid in our selection of treatment alternatives:

Has your child reached puberty yet? Y N

GIRLS: Has she started her cycle? Y N When? _____

BOYS: Has his voice changed? Y N When? _____

Father's Height _____ Mother's Height _____

Please indicate history of:

Y	N	Thumb/Finger Sucking	Y	N	Jaw Joint Problems
Y	N	Mouth Breathing	Y	N	Frequent Headaches
Y	N	Tongue Thrust	Y	N	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 of Parent or Guardian _____ Date _____