Dunn & Schreiber Orthodontics, PC

Patient's Name: _____ Patient's preferred name_____ Age _____

Male____ Female____ Married _____Single_____ Child _____ Birth Date _____/_____/_____

Address _____
Street City/State Zip Code

Patient's Home Phone _____ Patient's Cell Phone _____

Patient's Email Address _____Patient's Social Security # _____

Patient's School/Employer _____Work Phone _____

Whom may we thank for referring you to our office? _____

Medical/Dental History

Reason for seeking orthodontic treatment _____

Patient's Dentist _____ City _____Last Visit_____

Has anyone in your family ever had orthodontic treatment in our office? _____ If so, whom? _____

Does this family anticipate a move in the next 2-3 years?_____

Patient's physician _____ City _____ Last visit _____

Rate the patient's health ___Excellent ___Good ____Fair ___Poor

Has the patient been under a physician's care during the past 5 years, been hospitalized, or had any serious illness? _____ If yes, explain _____

Has the patient had a blood transfusion? _____ When? _____

Is the patient allergic to any medication or substance? ____Yes ____ No If yes, please name: _____

Name any medications the patient is currently taking _____

Has patient ever had any of the following? Please check any that apply:

- ❑ Abnormal Bleeding
- ❑ Hemophilia
- ❑ Anemia
- ❑ Bruise easily
- ❑ Asthma
- ❑ Breathing Problems
- ❑ Allergies
- ❑ High Blood pressure
- ❑ ADD/ADHD
- ❑ Autism
- ❑ Down's Syndrome
- ❑ Behavioral problems
- ❑ Birth Defects
- ❑ Endocrine disturbance
- ❑ Growth disturbance
- ❑ Low Blood Pressure
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Radiation Therapy
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Bone disease
- ❑ Frequent urination
- ❑ Excessive thirst
- ❑ Heart disease
- ❑ Prosthetic heart valve
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ Prosthetic joint
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Scarlet fever
- ❑ Epilepsy
- ❑ Convulsions
- ❑ Fainting spells
- ❑ Ulcers
- ❑ Tuberculosis
- ❑ Persistent cough
- ❑ Rickets
- ❑ Hemodialysis
- ❑ AIDS/ARC
- ❑ HIV
- ❑ Severe headaches
- ❑ Auto accident injury
- ❑ Tobacco (any form)
- ❑ Hepatitis
- ❑ Herpes
- ❑ Pregnancy

Spouse or Parent Information

Mother/Wife's Name_____ Social Security # _____

Birth Date_____ Employer _____ Email Address _____

Phone (Home) _____ Work _____ Cell _____

Address _____
Street City/State Zip Code

Father/Husband's Name _____Social Security # _____

Birth Date_____ Employer _____ Email Address _____

Phone (Home) _____ Work _____ Cell _____

Address _____
Street City/State Zip Code

Insurance Information

Name of Insured _____ Insurance Company _____

Insured's Birth Date _____ID# _____Group # _____

Insured's Address _____ Insurance Phone # _____

Employer _____ Employer's address _____

Patient's relationship to insured: ___Self ___Spouse ___ Child ___ Other _____

Emergency Contact (Someone NOT living in household)

Name: _____ Phone Number _____

Consent for Services

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Dr. S. Kendall Dunn or Dr. Alex C. Schreiber all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of the signature on all insurance claims.

_____ I hereby consent to treatment for myself, my child, or the above named minor, for whom I am legally responsible. The release of orthodontic information for insurance claims, the release of past medical payment history/credit history if requested, is authorized. I hereby acknowledge and accept full and final responsibility for payment of charges for orthodontic services rendered. I understand that if payments for further collection agency for further collection activity. I agree the fee charged is a legal and lawful debt and I agree to be responsible for any and all collection fees, attorney fees, and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the Constitution of Alabama or any other state.

I, the undersigned, give Dunn & Schreiber Orthodontics permission to take photographs of me or my child for promotional purposes of posting on social media sites, emailed new letters, and in office contests. I hereby release and discharge Dunn & Schreiber Orthodontics from any and all claims arising out of use of the photos.

I, the undersigned, give my permission to Dr. S. Kendall Dunn and Dr. Alex C. Schreiber and their employees to give the requested orthodontic care to myself/my child.

Signature of person filling out form _____SS# _____

Relationship to patient _____ Date _____