Please fill out completely and return to front desk

Patients Full Name: ________________________________
I prefer to be called: _____________________
Male _____ Female _____
Date of Birth: ____/_____/______ S.S. #: _____-____-______
Home Address: ________________________________
Street Name and Number/Apt.

____
City State Zip
Home Phone #: _(___)_____-_______Work Phone #: _(___)____-_____
What school does the patient attend? ____________________________
How did you hear about our office? _____________________________
Other family members seen by us: ______________________________

Our office sends reminders for scheduled appointments, please check below for your consent: ☐ Automated Phone Call Home Phone #: _ (____)_____-______
☐ Text Reminder Cell Phone #: _ (____)_____-______
☐ E-Mail Reminder E-Mail Address: ____________________________
(You can pick one or all three options, if you have any questions please see the front desk)

Name(s) of Parents/Guardians: ____________________ *Relationship*: _____________
____________________ *Relationship*: _____________
(*Please provide all responsible parties' information*)
Person Financially Responsible for the Account: ____________ Relationship**:___________**
Billing Address: __________________________________
Street Name and Number/Apt.

____
City State Zip
Home #: _ (___)____-________
Work #: _ (___)____-________ Spouse Work#:_(___)____-________
Mobile #: _ (___)____-_______ Alternate #: _(___)____-__________
Employer:__________________ Spouse Employer:__________________

In the event of an emergency please list someone living outside your home that we may contact: ______________________________ *Relationship:*___________________
Home #: _(___)____-________ Work #: _(___)____-__________

General Physician's Name: __________________________________

HOLMES PALMER
ORTHODONTICS

Telephone #: _(____)______-____________

Primary Dental Insurance Information
Insurance Company: __________________________________
Address: ____
Telephone #: ____________________ Ext. ___________
Insured's Name: ________________________________
Date of Birth: __________ S.S.#: ____________ ID/Group #: ___________
Employer: ____
Relationship to Patient: _________________________

Secondary Dental Insurance Information
Insurance Company: ___________________________________
Address: ____
Telephone #: ______________________ Ext. ____________
Insured's Name: ________________________________
Date of Birth: ___________ S.S. #: ____________ ID/Group #: __________
Employer: ____
Relationship to Patient: _____________________________

Dental and Medical History

General Dentist: _____________________Date of Last Cleaning: _____/_____/______
What are your main dental concerns?
____
Have you been seen by an orthodontist before? _____________
Dr.'s Name: _____________________ Date: _____/____/_____
Have you ever had an injury to your face or chin? __________________
Are there any medical conditions present that would require patient to pre-medicate before appointments? ____
Are there any medical conditions present that would not allow Cephalometric or Panoramic X-Rays? ___________________________
Do you generally breathe through your mouth or nose? ______________
Are you currently under the care of a physician? ___________
If so, please explain: ____
Are you taking any medications? If so, please list:
____
Are you pregnant? Yes _____ No _____

Are you allergic to latex? Yes _____ No _____
Are you allergic to nickel? Yes _____ No _____
Are there any other allergies or medical conditions that we should be aware of?
____

Circle any of the following diseases or medical problems that you currently have or have had in the past.

Abnormal bleeding	**Heart Surgery**	**High/low blood pressure**
Anemia	**Hemophilia**	**Hepatitis**
Asthma	**HIV/AIDS**	**Kidney Problems**
Blood Transfusion	**Heart Murmur**	**Rheumatic Fever**
Cancer	**Shingles**	**Severe Headaches**
Sinus Problems	**Ulcers/Colitis**	**Frequent Headaches**

I understand that the information supplied on this form is correct to the best of my knowledge.
I authorize the orthodontic staff to perform any necessary dental services that I might need during diagnosis and treatment with my informed consent.

_______________________________________ _____/______/_______
Signature **Date**

I understand that diagnostic records, photos, and the patient's name may be used for educational and promotional purposes.
I authorize,
Dr. W. Shane Holmes, Dr. Jack Palmer & Dr. Michael Signorelli
to review my records with my General Dentist, and/or Oral Surgeon.

____ ______/______/________
Signature **Date**

Hobbies & Interests: ____

____