northcut orthodontics

PETER A. SHAPIRO, DDS MSD PS

ORTHODONTICS FOR ALL AGES

PATIENT INFORMATION

DATE

LAST NAME	FIRST NAME	NICKNAME	SOC. SEC.#	SEX	BIRTH DATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

SCHOOL	GRADE	☐ SINGLE ☐ SEPARATED ☐ MARRIED ☐ DIVORCED	EMPLOYED BY / OCCUPATION	BUSINESS PHONE

WHOM MAY WE THANK FOR RECOMMENDING US?	NAME OF DENTIST	DATE OF LAST VISIT

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE

PATIENT INFORMATION (please complete if patient is a minor)

FATHER'S NAME: __________

ADDRESS (if different than patient's): __________

CITY: ______ ST: ______ ZIP: ______

HOME PHONE: ______ WORK PHONE: ______

EMPLOYER: __________

EMPLOYER ADDRESS: __________

CITY: ______ ST: ______ ZIP: ______

MOTHER'S NAME: __________

ADDRESS (if different than patient's): __________

CITY: ______ ST: ______ ZIP: ______

HOME PHONE: ______ WORK PHONE: ______

EMPLOYER: __________

EMPLOYER ADDRESS: __________

CITY: ______ ST: ______ ZIP: ______

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY / OCCUPATION

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

CELL PHONE	BUSINESS PHONE	SOC. SEC.#	E-MAIL ADDRESS

IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?	MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURED'S NAME: __________ SOC. SEC.# ______

INSURANCE COMPANY NAME: __________ GROUP# ______

INSURANCE COMPANY ADDRESS: __________

DO YOU HAVE DUAL COVERAGE? ☐ YES ☐ NO

2ND INSURED'S NAME: __________ SOC. SEC.# ______

INSURANCE COMPANY NAME: __________ GROUP# ______

INSURANCE COMPANY ADDRESS: __________

EMERGENCY INFORMATION

CONTACT PERSON IN CASE OF EMERGENCY: __________

PHONE # __________ RELATIONSHIP: ______

4915 25th Ave NE, Ste 203 Seattle, WA 98105 P 206.525.1999 F 206.525.3100 W northcutorthodontics.com

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MEDICAL HISTORY

Physician's Name:______________________ Address:______________________ Phone:______________________

Are you currently experiencing health problems? ☐ YES ☐ NO Explain:

Are you currently taking medications? ☐ YES ☐ NO List:

Are you allergic to any medications? ☐ YES ☐ NO List:

Women: Are you pregnant? ☐ YES ☐ NO Nursing: ☐ YES ☐ NO

Taking birth control pills? ☐ YES ☐ NO

Please check if you have had any of the following conditions:

☐ Heart Murmur
☐ Heart Surgery
☐ Kidney Disease
☐ Liver Disease
☐ Bone Disorders
☐ Asthma
☐ Epilepsy
☐ Hepatitis
☐ Diabetes
☐ HIV Positive
☐ Cancer
☐ Growth Disorders
☐ Mouth Breathing
☐ Allergies
☐ Emotional Disorder
☐ Rheumatic Fever
☐ Endocrine Disorder
☐ Tuberculosis
☐ Blood Disease
☐ Developmental Disorder
☐ Fainting

Is there any other condition or problem that you think we should know about?______________________

____

DENTAL HISTORY

Is there any unfinished dental care? ☐ YES ☐ NO

Are you apprehensive about dental treatment? ☐ YES ☐ NO

Have you had previous orthodontic treatment? ☐ YES ☐ NO With whom:

Have you noticed any changes in your bite or dental alignment? ☐ YES ☐ NO

What are your chief concerns related to your bite or the position of your teeth?

☐ Esthetics ☐ Cleaning ☐ Comfort ☐ Ability to Chew ☐ Stability

Please check if there is a history of:

☐ Clenching
☐ Grinding Teeth
☐ Ringing in the Ears
☐ Muscular Soreness Around Head and Neck
☐ Headaches
☐ Speech Problems
☐ Jaw Joint Soreness
☐ Jaw Joint Popping/Clicking

Is there any other information that may be helpful?______________________

____

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Patient Signature______________________ Date______________________

Health History Review:______________________

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