

Please print and fill out this form and return it to our office at your first appointment

LOEB ORTHODONTICS, P.A.
Orthodontics exclusively

Date _____

Patient's Name _____ Age _____ Date of Birth _____

Address _____ Home phone _____

City, State, Zip _____ Cell phone _____

What name do you prefer we call you? _____

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

Patient's dentist _____ Town _____

Have you ever received treatment involving: Gum disease _____ TMJ (jaw) problem _____

Oral surgery _____ Orthodontics _____

Occupation _____ Employer _____

Bus. Address _____

City, State, Zip _____ Bus. Phone _____

If you have orthodontic insurance, name of insurance company _____

Group/Policy name _____ Policy number _____

Social Security number (required - for insurance purposes only) _____

For our automated reminder service, choose your contact preference - select one & clearly write number:

Home phone _____ or Cell phone _____

E-mail address _____ needed for general office messages,

announcements, and web site interactivity

Special requests, considerations or comments _____



Medical-Dental Questionnaire:

Patient's Name _____ Date of Birth _____

MEDICAL HISTORY

Patient's Physician _____
Town _____ Phone _____

* Is your physician currently treating you for any reason?..... YES NO
If yes, explain _____

* Have you ever been hospitalized?..... YES NO
If yes,specify _____

* Are you currently taking any pills,drugs or other medicine?..... YES NO
If yes, please list: 1. _____ 2. _____
3. _____ 4. _____

* Women, are you pregnant? If yes, when do you expect? _____

* Do you have any or have you ever had any of the following?

- 1. Heart disease or chest pains
2. High Blood Pressure
3. Heart Murmur
4. Pacemaker or artificial valves
5. Rheumatic fever
6. Diabetes
7. Blood disorders or anemia
8. Lung or breathing problems
9. Asthma
10. Kidney or liver problems
11. Hepatitis
12. Thyroid problems
13. Stomach or intestinal problems
14. Tuberculosis
15. Arthritis
16. Artificial joint replacements
17. Epilepsy or seizures
18. Syphilis, gonorrhea, AIDS
19. Tumours or cancer
20. Radiation therapy
21. Shortness of breath

Please specify: _____

* Is there anything else concerning your health the doctor should know? _____

* Are you allergic to any medications or drugs?..... YES NO
If yes, explain _____

* Do you have any other allergies?..... YES NO
If yes, to what _____

DENTAL HISTORY

Patient's Dentist _____
Phone _____

* Approximate date of last dental checkup? _____
Was a full series of X-rays taken? _____

* Do you have discomfort in your teeth from hot, cold, sweets, chewing? _____

* Do you frequently wake up with a headache, or have a tired feeling
in your face or jaws? _____

* Do your jaw joints pop, click or grate when opening widely? _____

* Do you clench or grind your teeth? _____

I agree to notify you if there is any change in my (child's) health status.

Signature _____ Date _____

ATTENDING DENTIST'S STATEMENT

CARRIER NAME AND ADDRESS

CHECK ONE:
 _____ DENTIST'S PRE-TREATMENT ESTIMATE
 _____ DENTIST'S STATEMENT OF ACTUAL SERVICES

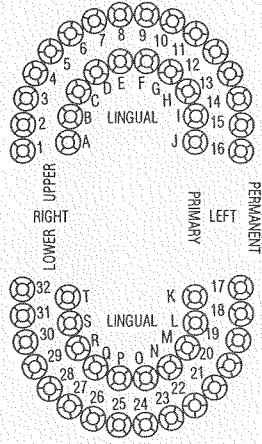
PATIENT COVERAGE INFORMATION	1. PATIENT NAME FIRST M.I. LAST	2. RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	3. SEX M F	4. PATIENT BIRTHDATE MO. DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY
	6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS	7. EMPLOYEE/SUBSCRIBER SOC. SEC. OR I.D. NUMBER	8. EMPLOYEE/SUBSCRIBER BIRTHDATE MO. DAY YEAR	9. EMPLOYER (COMPANY) NAME AND ADDRESS	10. GROUP NUMBER
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? DENTAL _____ MEDICAL _____		12-A. NAME AND ADDRESS OF CARRIER(S)	12-B. GROUP NO.(S)	13. NAME AND ADDRESS OF EMPLOYER	
14-A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)		14-B. EMPLOYEE/SUBSCRIBER SOC. SEC. OR I.D. NUMBER	14-C. EMPLOYEE/SUBSCRIBER BIRTHDATE MO. DAY YEAR	15. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____ SIGNED (INSURED PERSON) _____ DATE _____

BILLING DENTIST	16. NAME OF BILLING DENTIST OR DENTAL ENTITY	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES.
	17. ADDRESS WHERE PAYMENT SHOULD BE REMITTED	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	CITY, STATE, ZIP	26. OTHER ACCIDENT?			
	18. DENTIST SOC. SEC. OR T.I.N.	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?
21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?	30. IS TREATMENT FOR ORTHODONTICS?	IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH "X" FACIAL  FACIAL	31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.						FOR ADMINISTRATIVE USE ONLY
	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICES PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	
32. REMARKS FOR UNUSUAL SERVICES							

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (TREATING DENTIST)	LICENSE NUMBER	DATE	TOTAL FEE CHARGED
			MAX ALLOWABLE
			DEDUCTIBLE
			CARRIER %
			CARRIER PAYS
			PATIENT PAYS