

DR. SCOTT RUNNELS ORTHODONTICS

Monday, December 28, 2015

Patient Name: _____ Patient Nickname: _____
 Patients Address: _____ Primary Phone #: _____
 Birthdate: _____ Age: _____ Sex: _____
 Patient School: _____ Grade/Position: _____
 Patient E-mail: _____ Resp Party E-mail: _____
 Primary Responsible Party: _____ Relationship to patient: _____
 Home Address: _____ Primary Phone #: _____
 Employer Name/Address: _____ Alternate Phone #: _____
 Secondary Responsible Party: _____ Relationship to patient: _____
 Home Address: _____ Primary Phone #: _____
 Mother's Name: _____ Father's Name: _____
 How did you hear about us? _____ Present Dentist: _____
 Reason For Consultation: _____

Please circle any of the following for which the patient has a history:

Medical Conditions

AIDS/HIV	Cancer	Difficulty Breathing	Fainting/Dizziness	Muscular Disorders
Allergies	Cerebral Palsy	Downs Syndrome	Headaches	Nervous Disorders
Anemia	Chest Pains	Drug Allergies	Heart Condition	Perio Problems
Arthritis	Chronic Neck Pain	Emphysema	Hepatitis	Prolonged Bleeding
Asthma	Clicking of Jaw	Emotional Disorders	High/Low Blood Pressure	Psychiatric Treatment
Bone Disorders	Cold Sores/Herpes	Endocrine Problems	Immune Problems	Rheumatic Fever
Bulimia	Diabetes	Epilepsy/ Seizures	Kidney Problems	Scoliosis

Habits

Clenching	Poor Brushing
Grinding	Speech Problems
Finger Sucking	Thumb Sucking
Mouth Breathing	Tongue Thrust
Nail Biting	TMJ Pain
Nursing Bottle Habit	
Pacifier Habit	

Please Mark/ List Allergies: Latex Aspirin Metals/Plastic Codeine Erythromycin Penicillin Other

Other Medical Conditions? _____

Current Medications? _____

Females: Have you started Menstruating? If Yes, what age? _____ Have you had previous orthodontic treatment? _____

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Are there any missing or extra teeth? _____ Do gums bleed when brushed or flossed? _____

Have the Tonsils and adenoids been removed? _____ Tonsils and adenoids have not been removed _____ Any other questions? _____

Names and Ages of Brothers & Sisters: _____

Insurance Co Name: _____ Insurance Co Address: _____

Insurance Phone #: _____ Group Name/Number: _____

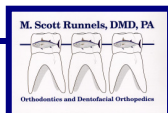
Policy Holder Name: _____ Social Sec/ID #: _____

Policy Holder Birthdate: _____

I authorize the office of Dr. Scott Runnels to release all treatment info to secure payment of benefits, as well as use this signature as authorization to file the initial insurance claim and all future claims on my behalf. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature: _____ Relationship To Patient: _____ Date: _____

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