



Today's Date:

Please review and complete entire form and edit the information that was automatically entered for you.

### Patient Information

<b>Patient Name</b>	<b>Patient's DOB:</b>
Nickname	_____
Gender	_____
Address	_____
Primary Phone	_____
Secondary Phone	_____

### Responsible Party Information

<b>First Responsible Party Name</b>	
Relation to patient	<input type="checkbox"/> Self <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced Spouse's Name: _____
Financially Responsible for account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address	_____
Primary Phone number	Secondary Phone: _____
Primary Resp. party Email (appt confirmation)	_____
<b>Second Responsible Party Name</b>	
Relation to patient	<input type="checkbox"/> Self <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced Spouse's Name: _____
Financially Responsible for account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address	_____
Phone number	_____
By signing you are authorizing to receive confidential info via Email and or Text including appt reminders.	<b>PLEASE SIGN</b>  X

### Insurance Information

Subscriber's Name	_____
Subscriber's DOB	_____
Subscriber's Street Address	_____
City, State & Zip	_____
Insurance Company Name	_____
Insurance Phone number	_____
Group Number	Subscriber's Employer _____
Insurance ID #	_____

Savastano & Dunn Orthodontics will need to share information with your insurance company. For optimum care your information will be shared with your general dentist and other dental specialist(s), if needed, to facilitate treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

HIPAA laws require our office to have authorization for whom we can release information regarding appointments, treatment and finances.

List those who we may discuss treatment: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

List those who we may discuss financial information: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**Medical and Dental History**

Physicians Name _____	_____
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**Circle Yes or No to the questions asked below: (if yes, please fill in details)**

Yes	No	Are you allergic to any medications?	Name of medication(s) _____
Yes	No	Are you allergic to Nickel or Latex?	List other allergies: _____
Yes	No	Do you have a history of a major illness?	Yes No Have your tonsils or adenoids been removed?
Yes	No	Have you had any major operations?	Yes No Have you ever been involved in a serious accident?

**List medications currently taking & dosage:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Circle any of the medical conditions below that you *have had* or *currently have*. Is medication needed prior to dental procedures? Y / N**

Abnormal bleeding/Hemophilia	Congenital Heart Defect	Hepatitis /Liver Problems	Pneumonia
ADD/ADHD	Diabetes	Herpes	Prolonged Bleeding
Anemia	Dizziness	High Blood Pressure	Radiation / Chemotherapy
Arthritis	Epilepsy	HIV or AIDS	Rheumatic Fever
Asthma or Hayfever	Gastrointestinal Disorders	Kidney Problems	Tuberculosis
Autism	Heart Problems	Nervous Disorders	Tumor or Cancer
Bone Disorders	Heart Murmur		

**Are there any other medical issues or conditions that we should know about?**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Dental History**

**Dentist:** Doctor South Lake Community Center **Date of Last Visit:** \_\_\_\_\_  
 Do you go for regular dental check-ups?  
 What concerns you most about your teeth?

**Circle Yes or No to the questions asked below: (if Yes, please fill in details)** **Details**

Yes No	Are you presently in any dental pain?	
Yes No	Have you ever experienced any unfavorable reaction to dentistry?	
Yes No	Have you ever lost or chipped any teeth?	
Yes No	Have there been any injuries to face, mouth or teeth?	
Yes No	Is any part of your mouth sensitive to temperature or pressure?	
Yes No	Do your gums bleed when you brush?	
Yes No	Do you have any type of thumb or tongue habit? Any other oral habit?	
Yes No	Are you a mouth breather?	
Yes No	Have you ever seen an orthodontist?	
Yes No	Has anyone in your family received orthodontic treatment?	
	How did they feel about the result?	
	What is your attitude toward receiving orthodontic treatment?	
Yes No	Are you aware of your jaw clicking or popping? Any jaw pain?	
Yes No	Do your teeth or jaws ever feel uncomfortable when you awake in the morning?	
Yes No	Are you aware of clenching your teeth during the day?	
Yes No	Have you ever been told that you grind your teeth?	
Yes No	Do you have "tension" headaches?	
Yes No	Have you ever experienced chronic ringing in your ears?	
Yes No	Are you aware that some appointments will be during school/work hours?	

**Benefits of Orthodontics Aesthetics, Health, and Function**

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and swollen gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment.

**Our office releases health information to the patient/parents insurance company, general dentist, and other dental specialists (if needed) to facilitate your treatment. \_\_\_\_\_ (initial)**

If insurance benefits are available and there is a balance on the account any and all insurance payments will be applied to the balance. In the event that an insurance payment is received and the account has a \$0 (zero) balance a refund will be issued to the subscriber of the insurance coverage.

I have read and understand the above paragraphs. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history. I have received, read and understand my Health Information (HIPAA) rights.

Signature: \_\_\_\_\_ Patient/Guardian Date 20 \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## How did you hear about us?

Referring new patients to our office is the highest compliment we can receive. Please take a moment to let us know all the ways you heard about our office. Put a check next to each source that applies then circle the main reason you selected our office and bring this to your appointment.

Thank you!

- |  |  |
|--|--|
| <input type="checkbox"/> DENTIST                   | <input type="checkbox"/> INTERNET SEARCH / WEBSITE                 |
| <input type="checkbox"/> FAMILY MEMBER / SIBLING   | <input type="checkbox"/> INSURANCE CO. / NETWORK PROVIDER LIST     |
| <input type="checkbox"/> FRIENDS / CO-WORKERS      | <input type="checkbox"/> INVISALIGN PROVIDER LIST                  |
| <input type="checkbox"/> BUILDING SIGN / LOCATION  | <input type="checkbox"/> ONE OF DR. SAVASTANO / DR. DUNN EMPLOYEES |
| <input type="checkbox"/> YELLOW PAGE LISTING       | <input type="checkbox"/> SPORTS TEAMS / SPONSORSHIP                |
| <input type="checkbox"/> GROUPON ADVERTISEMENT     | <input type="checkbox"/> FLORIDA BARTER / BARTER FIRST REFERRAL    |
| <input type="checkbox"/> SCHOOL ADVERTISEMENT      | <input type="checkbox"/> CMS / CLEFT PALATE TEAM REFERRAL          |
| <input type="checkbox"/> AUCTION CERTIFICATE       | <input type="checkbox"/> LAKE MARY LIFE MAGAZINE                   |
| <input type="checkbox"/> ALIVE AFTER 5 EVENT       | <input type="checkbox"/> WEKIVA LIFE MAGAZINE                      |
| <input type="checkbox"/> SCHOOL EDUCATION PROGRAMS | <input type="checkbox"/> OTHER, PLEASE SPECIFY _____               |

Please list all of your friends that referred you here so we may thank them properly.

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**Dr. Cara Wiewiora - Dr. Richard Dunn**  
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