Today's Date:

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

Patient Information

Patient Name **Patient's DOB:**

Nickname ______
Gender ______
Address ______
Primary Phone ______
Secondary Phone ______

Responsible Party Information

First Responsible Party Name ______
Relation to patient □ Self □ Mother □ Father □ Step Parent □ Grandparent □Other ______
Marital Status □ Married □ Single □ Divorced **Spouse's Name:**
Financially Responsible for account? □ Yes □ No
Address ______
Primary Phone number Secondary Phone:
Primary Resp. party Email (appt confirmation) ______

Second Responsible Party Name ______
Relation to patient □ Self □ Mother □ Father □ Step Parent □ Grandparent □Other ______
Marital Status □ Married □ Single □ Divorced **Spouse's Name:**
Financially Responsible for account? □ Yes □ No
Address ______
Phone number ______

By signing you are authorizing to receive confidential info via Email and or Text including appt reminders.

PLEASE SIGN

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	

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

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!

_____DENTIST
_____FAMILY MEMBER / SIBLING
_____FRIENDS / CO-WORKERS
_____BUILDING SIGN / LOCATION
_____YELLOW PAGE LISTING
_____GROUPON ADVERTISEMENT
_____SCHOOL ADVERTISMENT
_____AUCTION CERTIFICATE
_____ALIVE AFTER 5 EVENT
_____SCHOOL EDUCATION PROGRAMS
_____INTERNET SEARCH / WEBSITE
_____INSURANCE CO. / NETWORK PROVIDER LIST
_____INVISALIGN PROVIDER LIST
_____ONE OF DR. SAVASTANO / DR. DUNN EMPLOYEES
_____SPORTS TEAMS / SPONSORSHIP
_____FLORIDA BARTER / BARTER FIRST REFERRAL
_____CMS / CLEFT PALATE TEAM REFERRAL
_____LAKE MARY LIFE MAGAZINE
_____WEKIVA LIFE MAGAZINE
_____OTHER, PLEASE SPECIFY____________________

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

____

____

Dr. Cara Wiewiora • Dr. Richard Dunn
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550 Rinehart Road, Lake Mary, FL 32746 407-805-0068