Foothill Orthodontics
Where Perfect Smile Begins

PLACERVILLE
4282 Golden Center Dr. Ste 2
Placerville, CA 95667
Ph (530)622-1525

JACKSON
655 New York Ranch Rd.
Jackson, CA 95642
Ph (209)223-0525

foothill-ortho.com * Fax (530)419-3271 * 1foothillortho@gmail.com

Patient Registration

PATIENT INFORMATION

Name _____ Gender _____ Date _____

Address _____ City_____State_____ZIP_____

Home/Cell_____Work _____ Age _____ Birthdate _____

Financial Party_____Relationship to Patient _____

Email _____

Has any family member been a patient here before? ❑ Yes ❑ No If so, who? _____

Has any family member worn braces before? ❑ Yes ❑ No If so, who was the orthodontist?_____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Address _____ City_____State_____ZIP_____

Phone _____ Circle if applicable: Divorced / Separated

IF PATIENT IS A MINOR

Parent 1_____

Employer_____

Address _____

City _____ State____ ZIP_____

Phone_____

Soc.Sec.Number _____

Parent 2 _____

Employer_____

Address _____

City _____ State____ ZIP_____

Phone _____

Soc.Sec.Number _____

IF PATIENT IS AN ADULT

Employer_____

Position _____

Address _____

City _____ State____ ZIP_____

Phone_____

Soc.Sec.Number _____

DOB_____

Spouse_____

Employer_____

Address _____

City _____ State____ ZIP_____

Phone _____

Soc.Sec.Number _____

DOB _____

DENTIST INFORMATION

Name _____

Address _____ City_____State_____ZIP_____

Phone _____

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Patient Registration (continued)

INSURANCE_____

Primary Insurance

Policy Holder_____
Birthday_____Employer_____
Insurance Co._____
Insurance Phone _____
Address _____
City _____ State____ ZIP_____
Policy/Group#_____
Employee ID#_____

Secondary Insurance

Policy Holder_____
Birthday_____Employer_____
Insurance Co. _____
Insurance Phone _____
Address _____
City _____ State____ ZIP_____
Policy/Group#_____
Employee ID#_____

Insurance and Payment Authorization Release

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

Responsible Party_____ Date _____

I hereby authorize payment directly to Foothill Orthodontics of the group insurance benefits otherwise payable to me.

Responsible Party_____ Date _____

Please notify our office when your insurance changes.

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NEW PATIENT QUESTIONNAIRE

Name _____ Account# _____ Date _____

The following questions are designed to obtain the patient's health history and to help us understand what they want to achieve from orthodontic treatment. We will confirm this information when we present the patient's treatment options.

HEALTH INFORMATION _____

Does the patient have or has the patient ever had any of the following?

- ❑ High/Low Blood Pressure
- ❑ Diabetes
- ❑ Breathing through mouth frequently
- ❑ Rheumatic Fever
- ❑ STDs/AIDS/Herpes
- ❑ Asthma/Hay Fever
- ❑ Hepatitis/Jaundice
- ❑ Fainting Spells/Seizures
- ❑ Radiation Therapy
- ❑ Heart Trouble
- ❑ Arthritis
- ❑ Epilepsy
- ❑ ADD/ADHD
- ❑ Autism
- ❑ Other _____

Does the patient require antibiotics prior to treatment? Please list_____ ❑ Yes ❑ No

Is the patient in good health? _____ ❑ Yes ❑ No

Has there ever been a trauma to patients face teeth? Explain _____ ❑ Yes ❑ No

Is the patient presently under the care of Physicians for an illness or disease?_____ ❑ Yes ❑ No

Does the patient have a bleeding tendency or do wounds heal slowly?_____ ❑ Yes ❑ No

Has the patient been on Fosamax or any Bisphosphonates (drugs that hardens bone)?_____ ❑ Yes ❑ No

Is the patient allergic to nickel, latex, any drugs or medications? Please list_____ ❑ Yes ❑ No

My chief concerns are_____

CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT_____

The Teeth

- ❑ Don't like spaces between the teeth
- ❑ The teeth are crooked and overlapping.
- ❑ The teeth stick out too far.
- ❑ The mouth seems too small, not enough room for the teeth.
- ❑ The teeth are coming in the wrong places.

The Bite

- ❑ The patient feels there is a problem with the bite or has been told there is a problem.
- ❑ The patient has frequently or chronic pain in their jaws, face or head.
- ❑ The patient's jaws click, pop or lock when they open their mouths.
- ❑ The patient has or has had difficulty in opening and or closing their jaws.
- ❑ The patient clenches their teeth during the day or grinds their teeth during the night.
- ❑ There is a habit I am concerned about them or finger sucking.

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NEW PATIENT QUESTIONNAIRE (continued)

CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT_____

The dentist

- ❑ The patient visits the dentist regularly (every 6 months).
- ❑ The patient's last cleaning was (mm/yyyy) _____/_____
- ❑ The patient has not seen the dentist for over a year.

Dental problems

- ❑ The patient is not aware of dental problems other than misaligned teeth.
- ❑ The patient is aware of other dental problems that need attention. If so, what are they?_____

The orthodontist

- ❑ This is the patient's first experience with an orthodontist.
- ❑ The patient has worn braces before. _____(year)
- ❑ The patient has seen another orthodontist, and would like a second opinion._____(Dr. Name)

Patient expectations of orthodontic treatment

- ❑ The patient wants to find out if any treatment is needed.
- ❑ The patient only wants the upper teeth straightened and aligned.
- ❑ The patient only wants the lower teeth straightened and aligned.
- ❑ The patient wants the upper and lower teeth straightened in aligned.
- ❑ The patient wants all the teeth straightening and the bite corrected if possible.

Payment plans

- ❑ I am interested in paying for the total treatment at the beginning.
- ❑ I am interested in making monthly payment by
  - ❑ Cash
  - ❑ Check
  - ❑ ACH (no set up charge)
  - ❑ Credit Card (a transaction FEE is charged to the account)
  - ❑ My Online Banking Check