WILLIAM R. KINCER, D.M.D., P.C.

PRACTICE LIMITED TO ORTHODONTICS

NEW PATIENT INFORMATION

We consider it a privilege to welcome you to our office. In an effort to provide the best treatment possible, we ask that you complete this form as completely as possible. We value your time and appreciate your cooperation.

PATIENT

Name_____ _____ _____ Sex M/F
LAST FIRST MIDDLE

Address_____ _____ _____ _____
STREET CITY STATE

BIRTH DATE _____AGE_____ E-MAIL_____ SS#_____

PRIMARY PHONE_____ GENERAL DENTIST_____ LAST VISIT_____

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

PARENT/RESPONSIBLE PARTY

Name_____ _____ _____ _____
LAST FIRST M MARITAL STATUS

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Home Phone_____Cell_____Work_____ Ext.____

Relationship to Patient_____Employer_____ Occupation_____

PARENT/RESPONSIBLE PARTY

Name_____ _____ _____ _____
LAST FIRST MIDDLE MARITAL STATUS

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Home Phone_____Cell_____ Work_____Ext. _____

Relationship to Patient_____Employer_____ Occupation_____

INSURANCE INFORMATION

Insurance Company _____ Group No. _____ Insurance Phone_____

Policy Owner's Name_____Policy Owner's Employer_____

Policy Owner's Birthdate_____Policy Owner's ID#_____ Policy Owner's SS#_____

Insurance Co Address_____

Policy Owner Relationship to Patient_____ Lifetime Maximum Benefit_____

GENERAL INFORMATION

School _____Grade _____

Hobbies Siblings/Ages

Medical History

Medical Physician_____Phone _____ Last Visit_____

Is the child currently under the care of a physician? Yes _____ No _____

Yes, Please Explain

_____

_____

Has puberty begun? Yes _____ No _____ Has menstruation (period) begun? Yes ____ No ____ N/A _____

What are your main concerns regarding Orthodontic Treatment? _____

Has the patient ever been evaluated for orthodontic treatment? Yes _____ No _____
Any family members who have had orthodontic treatment?_____
Has the patient had tonsils or adenoids removed? Yes ____ No ____
Has the patient ever experienced jaw joint pain/discomfort (TMJ/TMD)? Yes ____ No ____
Does the patient have any missing or extra permanent teeth? Yes ____ No ____

Has the patient ever had an injury to : (select all that apply) Teeth ____ Mouth ____ Chin

Does the Patient display any of the following habits?

Clenching/ Grinding Teeth _____
Mouth Breathing _____
Tongue Thrusting _____
Thumb/Finger Sucking _____
Lip Sucking/Biting _____
Nail Biting _____
Prolonged Bottle/Pacifier _____
Speech Problems _____

Allergies to any of the following?

ASPIRIN _____
CODEINE ____
TETRACYCLINE____
ANY METALS/PLASTICS___
ERTHYROMYCIN____
PENICILLIN____
LATEX____
Any other allergies/sensitivities?

Drugs Patient is currently taking?

List any Serious Medical Condition(s) treated.

Signature

I understand that the information that I have provided 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.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor.

PRINT SIGNATURE