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.

ADULT PATIENT

NAME______________________ ______________________ __________ SEX ______

LAST FIRST MIDDLE

ADDRESS______________________ ______________________ __________ ______

STREET CITY STATE

ZIP

BIRTH DATE __________ E-MAIL______________________ MARITAL STATUS________

HOME PHONE____________CELL PHONE ____________ CELL CARRIER________(FOR TEXT REMINDERS)

EMPLOYER ______________________OCCUPATION ______________

GENERAL DENTIST______________________ LAST VISIT__________

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

SPOUSE/ADDITIONAL CONTACT

NAME______________________ ______________ ________ ______

LAST FIRST MIEEL3

MARITAL STATUS

ADDRESS______________________ ______________ ______ ______

STREET CITY STATE ZIP

BIRTH DATE ______________ E-MAIL______________________

HOME PHONE______________CELL______________
WORK______________ _EXT.. __________

EMPLOYER ______________________
OCCUPATION______________________

INSURANCE INFORMATION

Policy Owner's Name______________________Relationship to Patient______________

Policy Owner's Birth date ______________Policy Owner's Social Security # ______________

Policy Owner's Employer ______________Employer's Address ______________

Insurance Company ______________ Group No. ________ Policy Owner's ID#__________

Insurance Co. Address______________________

Insurance Co. Phone #______________________ Lifetime Maximum Benefit______________

Medical History

Are you under the care of a physician? Yes _______ No ____________ If yes, explain ____

Physician____Phone ___________________ Last Visit________________________

Address

____

Are you pregnant? Yes ______ No_______ If Yes, # of weeks____

What are your main concerns regarding Orthodontic Treatment? ____

Have you ever been evaluated for orthodontic treatment? Yes ______ No _______
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_____
Do you have any speech problems? Yes _____ No________ If Yes, explain ____
Do your gums bleed? Yes ________ No ________ Do you smoke? __________ Yes ______ No ________
Do you like your smile? Yes _____ No ________

Have you had, or do you have any of the following habits?

Clenching/ Grinding Teeth ___________
Mouth Breathing ________________________
Tongue Thrusting _____________________
Thumb/Finger Sucking ______________
Lip Sucking/Biting __________________
Nail Biting _________________________
Prolonged Bottle/Pacifier_____________

Allergies to any of the following?

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

List of drugs you are currently taking?

List any Serious Medical Condition(s) treated.

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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 medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor.

Date:

PRINT SIGNATURE