Darcy C. Cruikshank DMD, MSD, LLC
Lauren M. Weber DDS, MS, PC
SPECIALISTS IN ORTHODONTICS

*Today's Date*_____

Patient's First Name	Middle Initial	Last Name	Nickname	Date of Birth	Age	Gender

Patient's Dentist	Referred By

Orthodontic Insurance Carrier	Insurance Phone Number	Medical Savings Plan?

Who is financially responsible for this account?_____

Patient's marital status? Married_____Single_____Divorced_____Domestic Partnership_____Widow(er)_____Remarried_____

Please complete the following information so that we can properly communicate with insurance companies and other medical providers. Social security numbers are a requirement when we carry the contract. Thank you.

Patient

First Name_____
Last Name_____
Social Security #_____
Date of Birth_____
Address_____
City/State/Zip_____
Home Phone_____
Cell Phone_____
E-mail_____
Occupation_____
Employer_____
Work Phone_____

Patient's Spouse

First Name_____
Last Name_____
Social Security #_____
Date of Birth_____
Address_____
City/State/Zip_____
Home Phone_____
Cell Phone_____
E-mail_____
Occupation_____
Employer_____
Work Phone_____

PRIMARY DENTAL INSURANCE COMPANY

Insured Party_____
Relationship_____
Employer_____
Bus. Address_____
Date of Birth_____SS#_____
Ins. Co. Name_____
Address_____
Group #_____Group Name _____
Subscriber I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

Insured Party_____
Relationship_____
Employer_____
Bus. Address_____
Date of Birth_____SS#_____
Ins. Co. Name_____
Address_____
Group #_____Group Name_____
Subscriber I.D. # _____

Primary concern with teeth:_____

_____

_____

_____

Has the patient been under the care of a physician during the past two years?_____

Physician's name _____City_____

Is the patient taking any medication or drugs?_____

Does the patient have a history of major illness or hospital stay?_____

Please check the following that the patient has been diagnosed with:

- ☐ Allergies (seasonal)
- ☐ Allergies (metal)
- ☐ Allergies (latex)
- ☐ Allergies (medication)
- ☐ Asthma
- ☐ Congenital Defects
- ☐ Behavorial/Learning problems
- ☐ Diabetes (Type:_____)
- ☐ Epilepsy
- ☐ Headaches (Frequency_____)
- ☐ Heart Murmur
- ☐ HIV/Aids
- ☐ Injury to face/jaw (Please explain below)
- ☐ Rheumatic Fever
- ☐ Psychiatric Illness (examples: depression, bipolar, anxiety)
- ☐ Tuberculosis

Describe other medical concerns:_____

Special needs:_____

Have tonsils and adenoids been removed? If yes, what age?_____

Has the patient ever sucked a thumb or fingers? If yes, until what age?_____

Has the patient or other family members had any previous orthodontic treatment?_____

Has the patient been informed of any missing or extra permanent teeth?_____

Does the patient have any jaw pain or noise in the jaw joint?_____

Have there been injuries to the face, mouth or teeth?_____

Women only: Is there a possibility of pregnancy? Expected delivery date_____

May we thank someone for referring you to our office?_____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature_____Today's date_____