RESTREPO ORTHODONTICS

PATIENT INFORMATION FORM

NAME:_____ BIRTHDATE:_____
ADDRESS:_____City_____Satat_____Zip_____
MALE_____FEMALE_____ Telephone_____, Cellphone _____
PLACE OF EMPLOYMENT/SCHOOL_____
DENTAL INSURANCE:_____GROUP #_____
HOW DID YOU HEAR ABOUT OUR PRACTICE_____
EMAIL:_____

FAMILY INFORMATION

NAME:_____ BIRTHDATE:_____
ADDRESS:_____City_____Satat_____Zip_____
RELATIONSHIP_____Telephone_____, Cellphone _____
DENTAL INSURANCE:_____GROUP #_____

MEDICAL INFORMATION

PHYSICIAN:(Name/Phone)_____
DENTIST (Name/Phone)_____
LIST ALL MEDICATION YOU ARE PRESENTLY TAKING_____
_____
LIST ALL ALLERGIES _____
HAVE YOU BEEN HOSPITALIZED_____

DO YOU HAVE/HAVE YOU HAD	YES/NO		YES/NO
History of Congenital Heart Defects	___ __	Chronic Headaches	___ ___
History Of Heart Disease	___ ___	Cancer/Radiation Treatment	___ ___
History of Heart Surgery	___ ___	Lung Disease/Tuberculosis.	___ ___
Hepatitis	___ ___	Prolonged Bleeding /Anemia.	___ ___
Arthritis	___ ___	Epilepsy	___ ___
Abnormal Blood Pressure	___ ___	Pacemaker/Defibrillator	___ ___
Diabetes	___ ___	HIV Positive	___ ___
Asthma / Sinus trouble	___ ___	Ulcer / Stomach Problems	___ ___
Glaucoma/Eye Disorder	___ ___	Hip/ Joint Replacement	___ ___
Jaundice/Kidney Problems	___ ___	Emotional/psychological concerns.	___ ___
Pin /screw placement	___ ___	Pregnancy	___ ___
Jaw Pain/ TMJ Syndrome	___ ___		

PLEASE LIST OTHER CONDITION, TREATMENT OR SURGERY NOT MENTIONED ABOVE

_____

AUTHORIZATION

I hereby authorize the dental ossicle to administer such medications and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. I authorize the release of my dental/medical records and treatment information to my insurance company, doctors and care givers.I have received a copy of the notice of privacy practice and I have give my consent to the use and disclosure of my personal health information to carry out treatment, payment activities, and healthcare operations, (You may revoke this consent at any time by giving written notice.) I authorize Restrepo Orthodontics to mail to me practice information, appointment notices, treatment information, or dental educational materials. The information on this page, including the medical history, is correct and complete.

DATE:_____ SIGNATURE_____Seft____ Parent or guardian_____