Thank you for choosing Trulove & Foy Orthodontics. Please complete this form in ink, front and back. Ask if you need assistance.

Patient Information (Please Print)

Name____age______gender_________
First Middle Last

Birthdate______________SS#________________DL#_________________Home Phone#__________________

Address____City_________________State________Zip________

Employer__________________________________Occupation______________________Work #_____________

Employer Address____City_____________State_____Zip_________

E-Mail____Cell#_________________________________

Are you: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

If patient is a student, name of school/college: ____
Person to contact in case of an emergency_____________________________________Phone #____________
Who may we thank for referring patient to us? ____
Name(s) of any family members we have treated____
In your own words, what is patient's problem? ____

Dental History

Name of Dentist____Date of last exam______________________
Please check any of the following conditions that apply to patient:

( ) Bad Breath	( ) Crowns	( ) Jaw Pain	( ) Sensitivity to Cold
( ) Bleeding	( ) Earaches	( ) Loose Teeth	( ) Sensitivity to Hot
( ) Bridgework	( ) False Teeth	( ) Neck Pain	( ) Sensitivity to Sweets
( ) Broken Fillings	( ) Food Between Teeth	( ) Partial Dentures	( ) Sensitivity when Biting
( ) Clicking/Popping Jaws	( ) Grinding Teeth	( ) Periodontal Care	( ) Sores/Growth in Mouth
( ) Cleft Palate	( ) Headaches	( ) Mouth Breather	

Medical History

Name of Physician____Date of last exam______________
Please list all medications patient is currently taking:____
____
Allergies: ____

(Women) Is patient pregnant? ( ) Yes ( ) No / Taking Birth Control? ( ) Yes ( ) No
Does patient have a history of any of the following?

( ) AIDS	( ) Circulatory Problems	( ) HIV Positive	( ) Shortness of Breath
( ) Anemia	( ) Cough, Persistent	( ) Kidney Disease	( ) Skin Rash
( ) Arthritis, Rheumatism	( ) Cough up Blood	( ) Liver Disease	( ) Stroke
( ) Artificial Heart Valves	( ) Diabetes	( ) Major Surgery	( ) Swelling of Feet
( ) Artificial Joints	( ) Epilepsy	( ) Mitral valve Prolapse	( ) Thyroid Problems
( ) Asthma	( ) Fainting	( ) Nervous Problems	( ) Tobacco habit
( ) Back Problems	( ) Glaucoma	( ) Pacemaker	( ) Tonsillitis
( ) Blood Disease	( ) Heart Murmur	( ) Psychiatric Care	( ) Tuberculosis
( ) Blood Transfusion	( ) Heart Problems	( ) Radiation Treatment	( ) Ulcer
( ) Cancer	( ) Hemophilia	( ) Respiratory Disease	( ) Venereal Disease
( ) Chemical Dependency	( ) Hepatitis	( ) Rheumatic Fever	
( ) Chemotherapy	( ) High Blood Pressure	( ) Scarlet Fever	

Describe heart problems____
Does patient require premedication?____

Authorization
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to health of patient. I authorize the orthodontist to release any information including the diagnosis and the records of any treatment or examination rendered to patient during the period of such orthodontic care to third party payers and/or health practitioners. I understand that dental insurance may pay less than the actual amount owed for services. I agree to be responsible for payments of all services rendered on my or patient's behalf.

____Date________________________
Signature of Patient (or Guardian of patient is a minor)

Parent Information (Please complete if patient is a minor)

Father's Name__________________________DOB______________
Address____
City__________________________ST_________Zip_____________
Home Phone__________________Work Phone________________
SS#_____________________________DL#___________________
Employer____
Occupation____
Address____
City___________________________ST_________Zip___________
E-Mail_________________________________Cell#_____________

Mother's Name__________________________DOB_____________
Address____
City__________________________ST___________Zip___________
Home Phone_____________________Work Phone_______________
SS#_________________________DL#________________________
Employer____
Occupation____
Address____
City_____________________________St________Zip______________
E-Mail________________________________Cell#________________

Responsible Party Information (If patient is a minor, give parent or legal guardian information.)
NOTE: We cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent.

Relationship to patient:____
Name____Home phone__________________________
Address____
SS#__________________________Driver license#______________________Birthdate____________________
Employer__________________________Occupation_________________________Birthdate__________________
Address____
E-Mail____Cell #_____________________________
Are you: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Consent for Diagnostic Records

I, ____, do consent to Trulove & Foy Orthodontics taking any necessary diagnostic records, consisting of x-rays, photographs, and dental impression, for______________________________in order to diagnose and formulate an orthodontic treatment plan. I understand that Trulove & Foy Orthodontics will assist in filing for any insurance benefits I am entitled to receive, but that ultimately I, and not my insurance company, will be responsible for paying all charges associated with services performed. I also waive now and forever my right of exemption from legal action under the constitution of the state of Alabama and all other states. I also agree to pay all costs associated with the collection of any balance on the above patient's account, including but not limited to, late fees, collection costs, reasonable attorney's fees, and court costs. If divorce is involved, who is the custodial parent? ______________________
May patient information be released to the non-custodial parent? ( ) Yes ( ) N0. Note: Payment is due in full the day diagnostic records are made. ____ ____________________________________
Signature Date

Dental Insurance Information Name of Patient____
Note: Insurance information must be completely filled out in order to file for your benefits.

Primary Insurance Co.____ Address____
Group #________________________ Contract #_____________________________________Phone #____________________________
Employer____Employer Date__________________________________
Insured Name____Date of Birth____________SS #_________________________
Relationship to Patient____________________________________Lifetime Orthodontic Maximum ____________________________
I authorize the release of any information related to this claim

Signature____Date____

Secondary
InsuranceCo.____Address____
Group #________________________ Contract #_____________________________________Phone #____________________________
Employer____Employer Date__________________________________
Insured Name____Date of Birth____________SS #_________________________
Relationship to Patient___________________________________Lifetime Orthodontic Maximum $___________________________
I authorize the release of any information related to this claim

Signature____Date____