

"We Create Beautiful Smiles... One At A Time"

Towson Office: 120 Sister Pierre Dr., #502, Towson, MD 21204

Phoenix Office: 3326 Paper Mill Rd, Phoenix, MD 21132

Patient Information

Patient Name: _____.

Address: _____.

Home Phone: _____ Cell Phone: _____.

Birth Date: _____ Email Address: _____.

General Dentist: _____.

Name	Address	Phone
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Referred by: _____.

Responsible Party Information

Name: _____ Marital Status: _____.

Address: _____.

Mailing Address: _____.

Home Phone: _____ Cell Phone: _____.

Relationship to Patient: _____ Birth Date: _____.

Social Security #: _____ Employer: _____.

Spouse's Name: _____ Relationship to Patient: _____.

Insurance Information

Policy Holders Name: _____ Policy ID#: _____.

Insurance Company: _____ Group #: _____.

Policy Holder's Birth date: _____.

I hereby instruct and direct that my insurance company is to pay directly to: KWONG ORTHODONTICS, the dental expense benefits allowable & otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. Insurance benefits are not a guarantee of payment. Patient co pays are an estimate and I am responsible for any unpaid balance. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature of Policy Holder: _____ **Date:** _____

Medical History

Physician Name: _____ Phone: _____
Address: _____
Date of last physical: _____ Results: _____
Is patient receiving any medication? Y N If yes, list names & Purpose: _____

Have you had any history of or difficulty with any of the following? Please circle yes/no.

Y N A.I.D.S / H.I.V	Y N Developmental Disability	Y N Liver Disease
Y N Anemia	Y N Diabetes	Y N Cognitive Disability
Y N Asthma	Y N Epilepsy or Fainting	Y N Osteoporosis-if yes, what medication
Y N Bladder Problems	Y N Growth Disorder	Y N Prosthetic Implant
Y N Blood Transfusion	Y N Hay Fever	Y N Rheumatic Fever
Y N Bruise Easily	Y N Hearing Problems	Y N Sinus Problems
Y N Cancer	Y N Heart Murmur	Y N Thyroid Disease
Y N Cerebral Palsy	Y N Hepatitis	Y N Tuberculosis
Y N Cleft Lip/Palate	Y N Jaundice	Y N Any injury to teeth or jaws
Y N Convulsions	Y N Kidney Disease	

Are you allergic to, or ever had adverse reaction to the following? If yes, please circle:

Aspirin Amoxicillin Metal Latex Local Anesthetic Sedatives Any Others _____

If pregnant, what month _____ Initial _____ Date _____

Notice of Privacy Practices

I have read and understand the office Notice of Privacy Practices, and I am aware that a copy of the policy is available upon request.

Signature: _____ Date: _____

Initial and date for X-RAY authorization: Initial: _____ Date: _____