TINHAN
ORTHODONTICS

Welcome to our office

Please fill out this form completely so that we may provide you with the best care possible. We will be happy to help you with any questions.

Patient Information

Name of Patient_____birth date _____m f
Street_____city _____state____zip code_____
Home phone_____cell/work phone_____ social security #_____
If student,
School _____grade level_____
Employer _____ occupation _____
If military, rank and rotation date _____
E-mail address _____

Parent/Legal Guardian

Please fill in the information below as it applies to the minor patient;
Name of **mother**_____birth date_____
Street _____city_____ state_____zip code_____
Home phone_____cell/work phone_____social security #_____
Employer_____occupation_____
If military, rank and rotation date_____
Name of **father**_____ birth date_____
Street_____state _____zip code_____
City_____cell/work phone_____social security #_____
Employer_____occupation_____
If military, rank and rotation date_____

Spouse/Partner

Name_____birth date_____
Street_____city_____zip code_____
Home phone_____cell/work phone_____social security #_____
Employer_____occupation_____
If military, rank and rotation date_____

Insurance Information

Primary insurance company_____
Policy number _____group number_____
Subscriber name_____ birth date _____
Secondary insurance company_____
Policy number _____group number_____
Subscriber name_____ birth date _____

Medical and Dental history

Name of current dentist_____ referred by _____
Street_____ city & state _____
Date of last visit_____ date of last x-rays _____
Do you have any clicking, popping or joint/jaw pain?_____
Has your doctor told you to take antibiotics prior to dental procedures?_____
Have you had any serious illness or operation?_____
If yes, please explain_____
Are you now under the care of a physician?_____
If yes, what condition is being treated?_____
Are you taking any medication?_____
If yes, please list all medications_____
Are you allergic to any medications?_____
If yes, please list _____
Are you allergic to latex?_____ Other allergies?_____
Are you pregnant?_____ If there is a possibility, please tell the assistant before any x-rays are taken.
Have you had any of the following diseases or problems? Please circle all that apply.

AIDS	anemia	arthritis	artificial joints	asthma
back pain	cancer	chemotherapy	jaw pain	diabetes
headaches	kidney problems	HIV positive	hepatitis	allergies

Have you had any abnormal bleeding during dental surgery/extractions or trauma?
If yes, please explain _____
Do you have any blood disorders? _____
Have you had any heart diseases? _____
If yes, please explain _____

Rheumatic fever	yes	no
Congenital heart disease	yes	no
Cardiovascular disease	yes	no
Scarlet fever	yes	no
Mitral valve prolapse	yes	no

Have you been tested for tuberculosis? _____ date _____ Result: positive negative
Any other problems? Please explain _____

I have had the opportunity to review or read the office policy regarding HIPAA regulations, and to ask questions if necessary. If you are pregnant or may be pregnant, or if there is any reason an x-ray should not be taken, please inform us. I verify that I am legally authorized to seek advice and/or treatment for this patient.

Signature of responsible party_____
Printed name_____ date_____
Relationship to Patient_____

The above signed agrees to allow the use of all diagnostic orthodontic records, including photographs made in the process of examination, treatment and retention for the purpose of professional consultations, research, education or publication in professional journals. Authorization is also granted to allow Erik K. TinHan, M.A., D.D.S., Inc. to provide other health care providers, attorneys and third party insurance carriers, with information regarding orthodontic care, and that once released, Erik K. TinHan, M.A., D.D.S., has no responsibility for any further release by the individual receiving this information. The above signed also agrees to be responsible for this account. Payment is due on the first day of the month. If not paid within 7 days, a late fee may be charged. The responsible party further authorizes Erik K. TinHan, M.A., D.D.S. Inc., to file insurance claims for services provided. If the account is placed in the hands of an attorney or licensed collector for collection, the undersigned agrees to pay all costs for collection, including reasonable attorney's fees. Should an extended payment plan be accepted, the above signed understands that a credit verification may be accomplished.