DR. SCOTT RUNNELS ORTHODONTICS

Monday, December 28, 2015

Patient Name: ______________________ **Patient Nickname::** ______________________

Patients Address: ______________________ **Primary Phone #:** ____________

Birthdate: ____________ **Age:** ____________ **Sex:** ____________

Patient Status: € Single €Married € Divorced € Widowed € Separated

Patient E-mail: ______________________

Primary Responsible Party: ______________________ **Relationship to patient:** ____________

Home Address: ______________________ **Primary Phone #:** ____________

Employer Name/Address: ______________________ **Alternate Phone #:** ____________

Secondary Responsible Party: ______________________ **Relationship to patient:** ____________

Home Address: ______________________ **Primary Phone #:** ____________

Spouses Name (If Applicable): ______________________

How Did You Hear About Us? ______________________ **Present Dentist:** ____________

Reason For Consultation: ______________________

Please circle any of the following for which the patient/you have a history:

Medical Conditions

AIDS/HIV	Cancer	Difficulty Breathing	Fainting/Dizziness	Muscular Disorders
Allergies	Cerebral Palsy	Downs Syndrome	Headaches	Nervous Disorders
Anemia	Chest Pains	Drug Allergies	Heart Condition	Perio Problems
Arthritis	Chronic Neck Pain	Emphysema	Hepatitis	Prolonged Bleeding
Asthma	Clicking of Jaw	Emotional Disorders	High/Low Blood Pressure	Psychiatric Treatment
Bone Disorders	Cold Sores/Herpes	Endocrine Problems	Immune Problems	Rheumatic Fever
Bulimia	Diabetes	Epilepsy/ Seizures	Kidney Problems	Scoliosis

Habits

Clenching	Poor Brushing
Grinding	Speech Problems
Finger Sucking	Thumb Sucking
Mouth Breathing	Tongue Thrust
Nail Biting	TMJ Pain
Nursing Bottle Habit	
Pacifier Habit	

Please Mark/ List Allergies: € Latex € Aspirin € Metals/Plastic € Codeine € Erythromycin € Penicillin €Other ____________

Current Medications? ______________________

Females: At what age did menstruation start? ____________ **Females: Are you currently pregnant?** ____________

Have wisdom teeth been extracted? ____________ **Any face, mouth or teeth injuries?** ____________

Are there any missing or extra teeth? ____________ **Do gums bleed when brushed or flossed?** ____________

Have the Tonsils and adenoids been removed? ____________ **Have you had previous orthodontic treatment?** ____________

Names and Ages of Children: ______________________

Insurance Co Name:______________________ **Insurance Co Address:**______________________

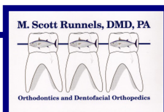
Insurance Phone #:______________________ **Group Name/Number:**______________________

Policy Holder Name:______________________ **Social Sec/ID #:**______________________

Policy Holder Birthdate:______________________

I authorize the office of Dr. Scott Runnels to release all treatment info to secure payment of benefits, as well as use this signature as authorization to file the initial insurance claim and all future claims on my behalf. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my/patient's medical status.

Signature: **Relationship To Patient:** **Date:**



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