



Jeffrey E. Kashner DDS, MSD

ORTHODONTICS
and Dentofacial Orthopedics

Welcome to our practice!

We would like to welcome you to our office. Our goal is to make your visit pleasant and informative. We are excited that you have made this commitment to improving your dental health. You will be pleased with the benefits orthodontics can make to your overall health. Thank you for taking the time to fill out this form. Please remember to bring it to your exam appointment.

Please tell us about yourself:

Today's date: _____

Name: _____ Male _____ Female _____

Nickname: _____ Birth Date: ____/____/____ Age: _____

Home phone #: _____ e-mail: _____

Home address: _____
City State Zip

Marital Status: ____single ____married ____widowed ____divorced ____separated

Work #: (____) _____ ext: _____

Employer: _____ How long at current job: _____ Job Title: _____

SS #: _____

Hobbies/Sports: _____

Dentist: _____ Did they refer you to us? ____Yes ____No

Is there someone else we can thank for referring you to our office? _____

Emergency Contact Name _____ Phone number _____ Relationship _____

Person responsible for account:

Name: _____ Relation: _____

Home #: (____) _____ SS#/ID#: _____

Employer: _____ Wk#: (____) _____ ext _____

Best time to call? _____ Is it alright to call at work? Yes ____No ____ Best #: _____

Primary Orthodontic Insurance: Coverage? ____yes ____no

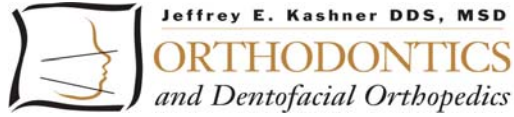
Insurance Co. Name: _____ Phone #: _____

Insurance Co. Address: _____

Group #: _____ Policy owner's name: _____

Relationship to patient: _____ Birth date: ____/____/____

SS# or ID #: _____ Policy owner's employer: _____



Secondary Orthodontic Insurance: _____ Coverage? yes no
 Insurance Co. Name: _____ Phone #: _____
 Insurance Co. Address: _____
 Group #: _____ Policy owner's name: _____
 Relationship to patient: _____ Birth date: ____/____/____
 SS# or ID #: _____ Policy owner's employer: _____

What are the main concerns that you would like orthodontics to address? _____

Have you ever been evaluated for or had orthodontic treatment before? Yes No
 Have there been any injuries to the face, mouth, teeth or chin? Yes No
 Have you been informed of any missing or extra permanent teeth? Yes No
 Have you ever had any pain / tenderness in your jaw joint (TMJ/TMD)? Yes No
 Do you floss your teeth daily? Yes No

Physician: _____ Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please describe your current physical health: Good Fair Poor

Please list all drugs that you are currently taking: _____

Have you ever had any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Abnormal bleeding			Diabetes			Asthma		
Handicaps/Disabilities			Hemophilia			Hearing impairment		
Allergies to any drugs			Heart Murmur			Any hospital stays		
Allergy to Latex/ Metals			Any operations			Hepatitis		
Any other allergies?			HIV + / AIDS			Cancer		
Kidney/liver problems			Congenital heart defect			Rheumatic/ Scarlet fever		
Convulsions/ Epilepsy			Tuberculosis (TB)					

Please comment on any (Yes) answers: _____

Please list any habits (thumb /finger sucking, nail biting, etc.) that you have or had in the past. _____

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 medical status.

Signature _____ Date _____
 I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance. I understand that I am responsible for any portion my insurance carrier does not pay.

Signature _____ Date _____