MONTINI
ORTHODONTICS

For Adults:
Welcome to our office! Thank you for choosing us for your orthodontic needs. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.
We look forward to being a part in creating your new smile!

PATIENT INFORMATION

Date: _____ Social Security #: _____ Date of Birth: _____

Name: _____ Sex: _____ Age: _____
Last Name First Name Middle Initial (Mr., Mrs., Ms.)

I prefer to be called: _____ Hobbies: _____

Home Address: _____
Street City State Zip

Cell Phone:(____) _____ Home Phone:(____) _____ Work Phone:(____) _____

Whom may we thank for referring you?: _____

Other family members seen by us: _____ Their relation to you?: _____

EMPLOYMENT

Your employer: _____ Occupation: _____ Email: _____

Business Address: _____
Street City State Zip

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Work Phone:(____) _____

RESPONSIBLE PARTY INFO

Name: _____ Social Security #: _____

Billing Address: _____
Street City State Zip

Work Phone:(____) _____ Home Phone:(____) _____ Cell Phone:(____) _____

Emergency Contact: _____ Their relation to you: _____

E.C. Home Phone:(____) _____ E.C. Work Phone:(____) _____ E.C. Cell Phone(____) _____

DENTAL INSURANCE

Insurance Name: _____ Group/Policy #: _____

Insurance Address: _____
Street City State Zip

Insurance Co. Phone #:(____) _____ Do you have secondary coverage: ☐ Yes ☐ No

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insured's Employer: _____ SS#: _____

DENTAL HISTORY

General Dentist: _____ Date of Last Visit: _____For What Services?: _____

Dentist Address: _____ Phone #:(_____)_____

	Yes	No		Yes	No
Have you ever had any serious dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Do you brush your teeth twice a day?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Do you floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, grinding, clenching, etc.?	☐	☐			

Your Dental Health: ☐Good ☐Fair ☐Poor Have you ever had any pain in the jaw joint (TMJ/TMD)? ☐Yes ☐No

Your Physician: _____City/State: _____ Phone #:(_____)_____

MEDICAL HISTORY

	Yes	No
Are you currently under the care of a physician?	☐	☐
Receiving any medications or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications: _____
_____
_____
Allergies: _____
_____

Have you ever had any history of or difficulty with any of the following? If yes, please check.

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other_____

AUTHORIZATION

To the best of my knowledge, the above is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Insurance Assignment and Release
I certify that I am covered by insurance with _____
Name of Insurance Company(ies)
and assign directly to Dr. Reid W. Montini all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctors may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end with the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature Date

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment?

If yes, please describe _____

Is patient taking any new medications: ☐ Yes ☐ No If yes, please list _____

Date: _____Patient Signature: _____

Date: _____Dentist Signature: _____