KAUAI ORTHODONTICS
Dr. Timothy R. Agee DMD MS

Patient's Name: _____ Nickname: _____ Date of Birth:_____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

◯Male ◯Female

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Patient's Marital Status: S M W D
Person responsible for account: _____
Business Phone: _____
Cell Phone: _____
Billing Address: _____
City: _____ Zip: _____
SSN: _____
DOB: _____

Spouse's Name: _____
Employer: _____
Business Phone: _____
Cell phone: _____

Patient's Dentist: _____ Referred By: _____ Patent's Physician: _____
Please describe the patient's problem or desired outcome: _____
_____

DOES THE PATIENT HAVE A HISTORY OF:

MEDICAL HISTORY

◯1)HEART TROUBLE/MURMUR
◯2)HIGH BLOOD PRESSURE
◯3)RHEUMATIC FEVER
◯4)STROKE
◯5)BLEEDING DISORDER
◯6) FREQUENT HEADACHE
◯7) DIZZINESS/FAINTING
◯8) THYROID DISORDER
◯9)KIDNEY DISORDER
◯10) LIVER DISORDER
◯11) SINUS DISORDER
◯12) ALLERGIES/HIVES
◯13) DIABETES
◯14) ARTHRITIS
◯15) TUBERCULOSIS (TB)
◯16) EPILEPSY
◯17) STOMACH DISORDERS
◯18) ANEMIA
◯19) CANCER
◯20)HEPATITIS
◯21) RESPIRATORY DISORDER
◯22) ASTHMA
◯23) PSYCHOLOGICAL DISORDER
◯24) TONSIL/ADENOID PROBLEM
◯25) SPEECH DISORDER

◯YES ◯NO 26) HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE LAST 2 YEARS?
◯YES ◯NO 27) HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION?
◯YES ◯NO 28) ARE YOU TAKING ANY DRUGS OR MEDICATIONS?
◯YES ◯NO 29) HAVE YOU BEEN DIAGNOSED WITH OSTEOPOROSIS, OSTEOPENIA OR TAKEN BISPHOSPHONATES?

DENTAL HISTORY

◯YES ◯NO 30) HAVE YOU HAD ANY TRAUMATIC INJURIES TO THE FACE, MOUTH, OR TEETH?
◯YES ◯NO 31) DO YOU HAVE A HISTORY OF THUMB OR FINGER SUCKING?
◯YES ◯NO 32) DO YOU HAVE A HISTORY OF LIP OR CHEEK BITING?
◯YES ◯NO 33) DO YOU HAVE A HISTORY OF CHRONIC MOUTH BREATHING?
◯YES ◯NO 34) DO YOU HAVE A HISTORY OF GRINDING OR CLENCHING YOUR TEETH?
◯YES ◯NO 35) HAVE ANY RELATIVES OR CLOSE FRIENDS BEEN A PATIENT IN OUR PRACTICE?

PLEASE ELABORATE ON ANY CHECKED ITEMS FROM ABOVE:

_____
_____
_____

ORTHO INSURANCE COMPANY:

PRIMARY INSURANCE COMPANY NAME: _____SUBSCRIBER'S NAME:_____

SUBSCRIBERS ID# OR SS#: _____ GROUP NUMBER: _____

SECONDARY INSURANCE COMPANY NAME: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBERS ID# OR SS#: _____ GROUP NUMBER: _____

As a courtesy to our patients, we will submit any necessary insurance claims provided that we have been informed of the current insurance coverage and have all necessary information needed to process the claim. The patient/parent/guardian will be responsible for any uncovered insurance portion.

I_____ (patient/parent/guardian), authorize the release of any necessary information for submission of any insurance claim.

_____

Signature Printed name Relationship Date

Sometimes records- (xrays, study models or diagnostic photographs) are necessary to complete the examination. If so, we will inform you prior to taking any records and we will give you an estimated cost.

I hereby authorize Timothy R. Agee, D.M.D. MS, to perform an orthodontic examination and take necessary records

_____

Signature Printed name Relationship Date