

# Initial Patient History Form

## Patient Information

Patient's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M F  
Residence \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Home Phone \_\_\_\_\_  
Hobbies \_\_\_\_\_  
If patient is a minor, give parent or Guardian's name \_\_\_\_\_  
How would the patient like to be addressed?  
\_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Marital status  
S M D  
Mailing Address (if different from above)  
\_\_\_\_\_  
\_\_\_\_\_  
How long at this address? \_\_\_\_\_  
e-mail Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Number of years employed \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Number of years employed \_\_\_\_\_  
Spouse's Social Security # \_\_\_\_\_  
Spouse's Date of Birth \_\_\_\_\_

## Responsible party information continued

Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

## Dental Insurance Information

Insured's Name \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Insured's SS No. \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone No. \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

Do you Have Dual Insurance? Y N

I certify that the information I have provided is true and correct. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts with the exception of proven Worker's Compensation injuries. By signing this statement, I revoke all previous agreements to the contrary. I also request that payment of authorized benefits be made on my behalf to Moles Orthodontics for services furnished by the provider. I authorize Moles Orthodontics to release to my insurance any information needed to determine these benefits or the benefits payable for related services. I understand that where appropriate, credit bureau reports may be obtained. Medicare patients agree to make payments directly to Moles Orthodontics at the time of each visit. In addition, I hereby give Moles Orthodontics permission to use photographs of my treatment for the purpose of informing and educating other professionals as well as for any print or broadcast publications.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

By signing below you are signifying that you have read, agree to, and if requested, received a copy of the Wisconsin Consent (HIPPA) form.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date