

# Initial Patient History Form

DATE \_\_\_\_\_

## 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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long at this address \_\_\_\_\_

e-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_

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

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

Social Security No. \_\_\_\_\_

Birthdate \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Number of years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Number of years employed \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION continued

Spouse's Social Security No. \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_

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

## INSURANCE INFORMATION

Insured's Name \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insured's SS # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_  
\_\_\_\_\_

Phone No. \_\_\_\_\_

Do you have dual coverage? Yes No Please circle

If yes, please complete the following:

Insured's Name \_\_\_\_\_

Insured's S. S. # \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_  
\_\_\_\_\_

Phone No. \_\_\_\_\_

Insured's Employer \_\_\_\_\_

I certify that the information I have provided is true and correct. I understand that my health care insurance carrier or payer of my health 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 that provider. I authorize Moles Orthodontics to release to my insurance carrier 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