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

5801 Washington Avenue
Racine, WI 53406-4098
262-884-7700

8555 W. Forest Home Avenue
Milwaukee, WI 53228-3408
414-529-4044

20350 Water Tower Blvd.
Suite 203
Brookfield, WI 53045
414-529-4044