Tsintolas ORTHODONTICS

Chris E Tsintolas, DDS, MS
Specialist in Orthodontics & Dentofacial Orthopedics

Patient Registration Form | ADULT
for individuals 18 years of age or above

Patient Information

patient's full [legal] name	first	middle	last	☐ male ☐ female

title [Mr., Mrs., Dr., etc.]	nickname/name preference	date of birth	today's date	age	social security number

patient's home address [street, apt. #, city, state, zip]

occupation	employer

first name of patient's dentist	last name of patient's dentist	Did your dentist refer you to Dr. Tsintolas? ☐ yes ☐ no

Please list the first and last name AND specialty of all other dental professionals participating in your care.

Other than your dentist, who/what directed you to Dr. Tsintolas? Please list all and be specific. [examples: friend's name, Google search, name of review site, etc.]

Have you ever visited us at: DrTOrthodontics.com ☐ Facebook ☐ Google+ ☐ Instagram ☐ Twitter ☐

Have you had orthodontic care before? What type of treatment and when?

Why are you consulting with an orthodontist?

Communication ► Please provide phone and e-mail contacts for the PATIENT ONLY; no contact information for other individuals.

Please provide ONLY the contact information we may use to convey urgent and non-urgent appointment, account, treatment, insurance, and other information. You may update as needed.

- **PHONE:** We require at least **ONE PHONE CONTACT FOR THE PATIENT.**
- **E-MAIL:** We convey important, helpful appointment and account reminders via e-mail; we strongly encourage providing e-mail address[es].
- **MAIL:** It is our policy to mail correspondence to the home address.

patient **HOME** phone	patient primary **E-MAIL**
patient **CELL** phone	patient secondary **E-MAIL**

Health Information ► Please check YES or NO to ALL. Do you have or have you ever had.....

	Yes	No		Yes	No		Yes	No		Yes	No
allergy to medications, anesthetics			artificial prosthesis, joint, heart valve			diabetes			consulted with another orthodontist		
allergy to acrylic or plastic			hormonal disorder			blood transfusion			periodontal [gum] disease		
allergy to latex [latex gloves, etc.]			kidney disorder			cancer			periodontal [gum] treatment		
allergy to nickel or other metal			liver disorder			hepatitis/jaundice			bleeding gums		
anaphylactic reaction			nervous disorder			fever blisters/cold sores			loose teeth		
currently under a physician's care			psychiatric care			HIV positive/AIDS			antibiotic premedication for dental care		
major operations			epilepsy/seizures			IV drug use			clicking and/or pain in jaw joints		
serious illness			sinus disorder			tattoos			trauma to face, mouth, and/or teeth		
taking any medications			autoimmune disorder			sexually transmitted disease [STD]			nail biting, pencil chewing, etc.		
heart trouble/disease			breathing disorder			drug addiction/alcoholism			finger sucking		
heart murmur			tuberculosis [TB]			in good health			grind/clench teeth		
high blood pressure			digestive disorder			**females**- pregnant/possibly pregnant			lip biting and/or lip sucking		
low blood pressure			bleeding disorder						speech problem		
rheumatic fever			asthma						difficulty swallowing		

List all current medications:	List all medication allergies:	Reserved for office use.

301.948.7513 | f. 301.926.3861 | 903 Russell Avenue, Suite 101 | Gaithersburg, MD 20879
www.DrTOrthodontics.com

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Emergency Contact ► In the event of an emergency, whom may we contact on your behalf?

Please provide **name**, **relationship**, and **phone contact**.

Account Information ► Please complete IF SOMEONE OTHER THAN YOU is financially responsible for your care - otherwise skip.

Responsible Party Other than Patient

Skip if patient is responsible for his/her own account.

Required: ONE HOME OR CELL PHONE + E-MAIL

title [Mr., Mrs., Dr., etc.]	first name	middle name	last name
relationship to patient ☐ father ☐ mother ☐ other [specify]			social security #
Is home address same as patient's? ☐ yes ☐ no	If no, please provide home address [street, apt. #, city, state, zip].		
HOME phone	**CELL** phone	primary **E-MAIL**	
occupation	employer		

Insurance Information ► We are unable to submit incomplete insurance claims, please provide ALL requested information.

Are you covered under an insurance policy that specifically includes **ORTHODONTIC** care? ☐ yes ☐ no ☐ unknown
Please know that **DENTAL** insurance may or may not include **ORTHODONTIC** care.

If **YES** or **UKNOWN**, please complete **ALL** the information below for each insurance provider. If **NO**, please skip.

Insurance Provider 1 with **ORTHODONTIC** benefits

insurance company name			insurance phone
insurance address for claim submissions [street, apt. #, city, state, zip]			effective date/date insurance coverage began
subscriber first name	subscriber m.i.	subscriber last name	subscriber birth date
subscriber ID number	group number	group name	policy number

Insurance Provider 2 with **ORTHODONTIC** benefits

insurance company name			insurance phone
insurance address for claim submissions [street, apt. #, city, state, zip]			effective date/date insurance coverage began
subscriber first name	subscriber m.i.	subscriber last name	subscriber birth date
subscriber ID number	group number	group name	policy number

Insurance Provider 3 with **ORTHODONTIC** benefits

insurance company name			insurance phone
insurance address for claim submissions [street, apt. #, city, state, zip]			effective date/date insurance coverage began
subscriber first name	subscriber m.i.	subscriber last name	subscriber birth date
subscriber ID number	group number	group name	policy number

Signature ► Sign, print name, and date where indicated in the boxes below.

- I consent to treatment.
- I understand the phone/e-mail communication policy; I have provided contacts only for which I approve receipt of urgent and non-urgent appointment, account, treatment, insurance, and other information. I may add and remove phone numbers/e-mail addresses at any time. This office requires at least one home or cell phone contact for patient and any other associated adult[s].
- I have reviewed and understand the Notice of Privacy Practices.
- I grant this office permission to utilize my orthodontic records [models, x-rays, photographs] and treatment records for research, instruction, scientific publication, and marketing. Patient anonymity will be preserved.
- I grant this office permission to release to insurance providers all information necessary to process claims and to transmit the information electronically.
- I grant this office permission to send and receive electronic transmission of x-rays, photographs, and treatment records. It is customary for this office to share patient records with the patient's other health professionals via e-mail.
- I grant this office permission to include my patient images and possibly the first name on social media. We will never publish the last name or any other specific identifier [such as school, home address, etc.] on social media.

PATIENT signature [for pages 1 and 2]	please clearly print your name	date

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