Tsintolas ORTHODONTICS

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

Patient Registration Form | CHILD & TEEN
for individuals under 18 years of age

Patient Information

patient's full [legal] name	first	middle	last	☐ male ☐ female
nickname/name preference	date of birth	today's date	age	
patient's home address [street, apt. #, city, state, zip]				
first name of **patient's** dentist	last name of **patient's** dentist	Did dentist refer patient to Dr. Tsintolas? ☐ yes ☐ no		
Other than patient's 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 ☐
Why are you consulting with an orthodontist?	What orthodontic treatment has patient had? When?			

Parent Information

Check One: ☐ **father** ☐ **stepfather** ☐ **grandfather** ☐ **guardian 1***	title [Mr., Dr., etc.]	first name	middle name	last name
	Is home address same as patient's? ☐ yes ☐ no	If no, please provide home address [street, apt. #, city, state, zip].		
Check One: ☐ **mother** ☐ **stepmother** ☐ **grandmother** ☐ **guardian 2***	title [Ms., Mrs., Dr., etc.]	first name	middle name	last name
	Is home address same as patient's? ☐ yes ☐ no	If no, please provide home address [street, apt. #, city, state, zip].		

***IF** ☒ guardian 1 selected, relationship to patient:
***IF** ☒ guardian 2 selected, relationship to patient:

So we may effectively communicate with you, please indicate relationship of above two individuals. ☐ married ☐ separated ☐ none apply ☐ divorced ☐ unmarried

Communication

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 EACH ADULT** associated with this patient.
- **E-MAIL:** We convey important, helpful appointment and account reminders via e-mail; we strongly encourage providing e-mail addresses.
- **MAIL:** It is our policy to mail correspondence to the home address.

Check One: ☐ **father** ☐ **stepfather** ☐ **grandfather** ☐ **guardian 1**	**HOME** phone	primary **E-MAIL**	
	CELL phone	secondary **E-MAIL**	
Check One: ☐ **mother** ☐ **stepmother** ☐ **grandmother** ☐ **guardian 2**	**HOME** phone	primary **E-MAIL**	
	CELL phone	secondary **E-MAIL**	
Patient	**HOME** phone	**CELL** phone	primary **E-MAIL**

Health Information ► Please check YES or NO to ALL. Does the patient have or ever had.....

	Yes	No		Yes	No		Yes	No		Yes	No
allergy to acrylic or plastic			artificial prosthesis, joint, heart valve			diabetes			previous orthodontic treatment		
allergy to medications, anesthetics			hormonal disorder			blood transfusion			consulted with another orthodontist		
allergy to latex [latex gloves, etc.]			kidney disorder			cancer			periodontal [gum] disease		
allergy to nickel or other metal			liver disorder			hepatitis/jaundice			periodontal [gum] treatment		
anaphylactic reaction			nervous disorder			fever blisters/cold sores			bleeding gums		
currently under a physician's care			psychiatric care			HIV positive/AIDS			loose teeth		
major operations			epilepsy/seizures			IV drug use			antibiotic premedication for dental care		
serious illness			sinus disorder			tattoos			clicking and/or pain in jaw joints		
taking any medications			autoimmune disorder			sexually transmitted disease [STD]			trauma to face, mouth, and/or teeth		
heart trouble/disease			breathing disorder			drug addiction/alcoholism			nail biting, pencil chewing, etc.		
heart murmur			tuberculosis [TB]			in good health			finger sucking		
high blood pressure			digestive disorder			**females**- pregnant/possibly pregnant			grind/clench teeth		
low blood pressure			bleeding disorder			**females 14 yrs. or younger ONLY**- age at onset of menstruation	age		lip biting and/or lip sucking		
rheumatic fever			asthma						speech problem		
									difficulty swallowing		

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

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www.DrTOrthodontics.com

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patient name

Account Information ► Complete for ALL individuals financially responsible for:

Responsible Party 1
Required: **ONE HOME OR CELL PHONE + E-MAIL**

title [Mr., Mrs., Dr., etc.] | first name | middle name | last name

relationship to patient ☐ father ☐ other [specify] ☐ mother | social security number

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

Responsible Party 2
Required: **ONE HOME OR CELL PHONE + E-MAIL**

title [Mr., Mrs., Dr., etc.] | first name | middle name | last name

relationship to patient ☐ father ☐ other [specify] ☐ mother | social security number

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.

Is the patient 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 **UNKOWN**, 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 of my child.
- 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 each adult associated with this patient.
- I have reviewed and understand the Notice of Privacy Practices.
- I grant this office permission to utilize the patient's 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 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.

PARENT/GUARDIAN signature [for pages 1 and 2] | please clearly print **PARENT/GUARDIAN** name | date

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