KOROPP ORTHODONTICS

Patient #			Exam Date		
PATIENT INFORMATION					
Patient's Last Name	**First**	**Middle**	**Primary Phone**		
Address			**Birth date** / /	**Age**	**Sex** ☐ M ☐ F
City	**State**		**ZIP Code**		
Dentist	**How would you like to receive automated reminders? (Check all that apply)** ☐ **Text Message** ☐ **Phone Call** ☐ **E-mail**				
Who may we thank for referring you to our office?					
If Patient is under 18 years of age please fill out the following questions.					
Parent's or Guardian's Names	**School**				
What are names and ages of siblings in household?					
RESPONSIBLE PARTY INFORMATION					
Last Name	**First**	**Middle**	**Marital Status**		
Physical Address:					
Mailing Address:					
How long at this address?	**Home Phone**	**Work Phone**	**Cell Phone**		
Previous Address (if less than 2 years)					
Primary Email	**Secondary Email**				
Social Security Number	**Relationship to Patient**				
Employer	**Occupation**		**Years Employed**		
Spouse's Last Name	**First**	**Middle**	**Relationship to Patient**		
Employer	**Occupation**		**Years Employed**		
Social Security Number	**Home Phone**	**Work Phone**	**Cell Phone**		
INSURANCE INFORMATION					
Subscriber's Name	**Primary Insurance I.D. Number**				
Primary Insurance Company	**Group Number**	**Subscriber's Date of Birth**			
Primary Insurance Company Address					
Primary Insured's Employer	**Primary Insurance Company Phone Number**				
Subscriber's Name	**Secondary Insurance I.D. Number**				
Secondary Insurance Company	**Group Number**	**Subscriber's Date of Birth**			
Secondary Insurance Company Address					
Secondary Insured's Employer	**Secondary Insurance Company Phone Number**				

CERTIFICATION OF ACCURACY

The above information is true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained. I authorize my insurance benefits be paid directly to Dr. Koropp. I understand that I am financially responsible for any balance. I also authorize Dr. Koropp's Office or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

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Health Questionnaire

Please answer each question regarding the patient. Check Yes or No where applicable.

DENTAL HISTORY

		YES	NO
Physician	**Oral Surgeon**		
1. Date of last dental examination?			
2. Is dental work complete?		☐	☐
3. How often do you brush your teeth?	**Floss?**		
4. Have you ever had an injury to your face or jaw?		☐	☐
5. Are you aware of tooth grinding or clenching habits?		☐	☐
6. Do you have speech problems?		☐	☐
7. Do you breathe mostly through your mouth?		☐	☐
8. Does orthodontic/dental treatment make you nervous?		☐	☐
9. Does your jaw make a "clicking" or "popping" sound when you chew?		☐	☐

MEDICAL HISTORY

Are you in good health?		☐	☐
1. Are you presently under the care of a physician?		☐	☐
If so, what is the condition being treated?			
2. Have you ever had any serious illnesses or operation?		☐	☐
If so, please list			
3. Are you taking any drugs or medication?		☐	☐
If so, please list			
4. Are you sensitive or allergic to any drugs?		☐	☐
If so, please list			
5. For minors, has the patient reached puberty?		☐	☐
Menstruated at Age	**Voice Changed at Age**		
Height	**Weight**		
6. Do you have a tendency to colds, sore throats, or ear infections?		☐	☐
7. Have you had your tonsils or adenoids removed?		☐	☐
8. Have you been exposed to or tested positive to HIV?		☐	☐
9. Do you have, or have you had any of the following? (Circle all that apply)			

Anemia	**Blood Diseases**	**Rheumatism or Arthritis**
Heart Ailments	**Hepatitis, Jaundice or Liver Disease**	**Head Injuries**
High Blood Pressure	**Kidney Disease**	**Stomach Ulcers**
Respiratory Conditions	**Tumors or Growths**	**Difficulty Swallowing**
Tuberculosis	**Radiation Treatment of any kind**	**Venereal Disease**
Nervous Disorders	**Allergies**	**Acquired Immune Deficiency**
Diabetes	**Asthma or Hay Fever**	**Epilepsy**
Excessive Bleeding	**Fainting Spells or Seizures**	**Mental Disorders**
Rheumatic Fever	**Artificial Prosthesis (Implants)**	**Stroke**
Glaucoma	**Herpes**	**Sinus Trouble**

10. Do you have any disease, condition or problem not listed?	☐	☐
If so, please list		

IN CASE OF EMERGENCY

Name of nearest relative not living with you	**Relationship to Patient**	
Complete Address	**Home Phone**	**Cell Phone**