DR. TROY M. LEFORT
ORTHODONTICS

Patient Name: _____ Patient Nickname: _____

Patients Address: _____ Primary Phone #: _____

Birthdate: _____ Age: _____ Sex: M /F Patient SS#: _____

Patient School: _____ Grade: _____

Patient E-mail: _____ Resp Party E-mail: _____

Primary Responsible Party: _____ Relationship to patient: _____

Home Address: _____ Primary Phone #: _____

Birthdate: _____ SS#: _____

Employer Name/Address: _____ Alternate Phone #: _____

Secondary Responsible Party: _____ Relationship to patient: _____

Home Address: _____ Primary Phone #: _____

Birthdate: _____ SS#: _____

Mother's Name: _____ Father's Name: _____

How did you hear about us? _____ Present Dentist: _____

Reason For Consultation: _____

Please check any of the following for which the patient has a history:

Medical Conditions

□AIDS/HIV	□Cancer	□Difficulty Breathing	□Fainting/Dizziness	□Muscular Disorders
□Allergies	□Cerebral Palsy	□Downs Syndrome	□Headaches	□Nervous Disorders
□Anemia	□Chest Pains	□Drug Allergies	□Heart Condition	□Perio Problems
□Arthritis	□Emphysema	□Hepatitis	□Prolonged Bleeding	□ChronicNeck Pain
□Asthma	□Clicking of Jaw	□Emotional Disorders	□High/Low Blood Pressure	□Psychiatric Treatment
□Bone Disorders	□Rheumatic Fever	□Cold Sores/Herpes	□Bulimia Diabetes	□Epilepsy/ Seizures
□Kidney Problems	□Scoliosis	□Endocrine Problems	□Immune Problems	

Habits

□Clenching □Poor Brushing □Grinding □Speech Problems □Finger Sucking □Thumb Sucking
□Mouth Breathing □Tongue Thrust □Nail Biting □TMJ Pain □Nursing Bottle Habit □Pacifier Habit

Please Mark/ List Allergies:
□ Latex □Aspirin □Metals/Plastic □Codeine □Erythromycin □Penicillin □Other_____

Other Medical Conditions? _____
Current Medications? _____
Females: Have you started Menstruating? _____ If Yes, what age? _____

Please complete the back of this page

Have you had previous orthodontic treatment? _____

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Are there any missing or extra teeth? _____ Do gums bleed when brushed or flossed? _____

Have the Tonsils and adenoids been removed? _____

Any other questions? _____

Names and Ages of Brothers & Sisters: _____

Insurance Information

Insurance Company: _____

Insurance Address: _____

Insurance Phone #: _____

ID: _____ Group #: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

For office use only:

Lifetime Maximun: _____ % Benefits Covered: _____ Amount Used: _____

Effective Date: _____ Waiting Period: _____ Age Limit: _____

Claims: Submit / Automatically Generated Monthly / Quarterly / Annually Payer ID: _____

I authorize the office of Dr. Troy M. Lefort to release all treatment info to secure payment of benefits, as well as use this signature as authorization to file the initial insurance claim and all future claims on my behalf. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature: _____

Relationship To Patient: _____ Date: _____

Permission for use of photos:

As part of our orthodontic family, we like to display who is new to our practice and who has recently completed treatment. We appreciate you granting permission for the use of these photos.

Signature: _____