Associated Orthodontists of Indiana, Inc. - Adult registration

Patient Name_____ Birthdate _____/_____/_____ AGE_____

Preferred Name _____ Male/Female Married _____Single_____ Divorced _____

Address _____
Street Apt# City State Zip

HOME# _____ Cell # _____ Work# _____

Email _____ Preferred Method of Contact _____

Social Security# _____-_____-_____ Employer _____

Occupation _____ Primary Insurance Co _____

Person responsible for Account _____ Secondary Insurance Co _____

Who referred you to this office? _____

MEDICAL HISTORY

Family Dentist_____ location _____ Phone#_____

Family physician_____ location _____ Phone#_____

	YES	NO
Are there any general health problems?	☐	☐
Please specify _____		
Any previous hospitalizations or surgeries?	☐	☐
Please specify _____		
Are medications being taken at this time?	☐	☐
Please list _____		
Do you have an allergy to any drug?	☐	☐
Please list _____		

Have you had any of the following afflictions?		
HIV Symptoms	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy	☐	☐
Respiratory Disease	☐	☐
Prolonged Bleeding	☐	☐
Hepatitis	☐	☐
Ear Problems	☐	☐
Nervous or Mental Disorder	☐	☐
Kidney or Liver Disease	☐	☐

Consent I will be responsible for the cost of my dental care, including attorney fees and court costs that maybe necessary to collect any outstanding balance on this account. By virtue of my signature on this document, I agree to bind myself, the patient, to be responsible for my treatment. In filing bankruptcy proceedings, either voluntary or involuntary, Associated Orthodontists of Indiana, Inc., reserves the right to terminate all future treatment and services. I also authorize Associated Orthodontists of Indiana, Inc., to release any information relating to insurance claims and hereby authorize payments to be made directly to Associated Orthodontists of Indiana, Inc.

_____ _____

Patient Signature Date