

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 _____	<input type="checkbox"/>	<input type="checkbox"/>
ANY PREVIOUS HOSPITALIZATIONS OR SURGERIES? PLEASE SPECIFY _____	<input type="checkbox"/>	<input type="checkbox"/>
ARE MEDICATIONS BEING TAKEN AT THIS TIME? PLEASE LIST _____	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE AN ALLERGY TO ANY DRUG? PLEASE LIST _____	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING AFFLICTIONS?

HIV SYMPTOMS	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
PROLONGED BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>
EAR PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS OR MENTAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>

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