739 President Place, #210
Smyrna, TN 37167
Phone 615-220-8585
Fax 615-220-8575

We would like to welcome you to our office.

All information is confidential. Thank you.

Date:_____ Patient's Full Name: _____DOB: _____

Age: _____ Male or Female Social Security #: _____

Home
Address:_____

Email Address _____

We require that we have at least 2 phone numbers for contact purposes

Hm. #:_____ Cell. #_____ Wk. # _____

Who may we thank for referring you to our office?_____

IF UNDER 18

School:_____ Grade: _____ Hobbies:_____
Siblings Name: _____Has any family member had braces before? If so, who?_____

Responsible Party

First Name: _____ Last Name:_____ MI:_____

SS# _____ DOB_____ Relation to Pt_____

Home Address:_____

Home phone:_____ Work Phone:_____

Previous Address (if less than 3 years): _____

Additional Responsible Information

First Name: _____Last Name: _____MI: ____ Marital Status _____
SS# _____ DOB _____ Relation to Pt._____
Home Address: _____
How long at this address? ____ Home phone: _____Work Phone: _____
Previous Address (if less than 3 years): _____

For your convenience we offer the following methods of payment. Please circle preferred option: Care Credit Debit or Credit Card Cash

INSURANCE POLICY HOLDER INFORMATION

Name of Insured _____ **DOB:** _____ **SS#** _____
Primary Ins. Co. _____ **ID#** _____ **Group #** _____
Insurance Co. Address / Ph. # _____
Employer Name _____ **How long Employed?** _____
Employer Address/Ph. # _____
Relation to Patient _____

Name of Insured _____ **DOB:** _____ **SS#** _____
Secondary Ins. _____ **ID#** _____ **Group #** _____
Insurance Co. Address / Ph. # _____
Employer Name _____ **How long Employed?** _____
Employer Address/Ph. # _____
Relation to Patient _____

EMERGENCY INFORMATION

Who may we contact in the event of an Emergency? _____
Hm. #: _____ C#. _____ Wk. # _____
Relation to Patient _____

DENTAL/MEDICAL HISTORY

Dentist Name: _____ Phone: _____ Last cleaning? _____
Physician Name: _____ Phone: _____ last visit? _____
Has an orthodontist previously been consulted? ____ If so, when? _____
What concerns would you like Orthodontics to accomplish? _____
Is the patient currently under a physician's care? _____ No _____ Yes
If yes, for what reason? _____
Have the tonsils and adenoids been removed? _____ No _____ Yes
Has the patient ever sucked a thumb or finger? _____ No _____ Yes
Until what age? _____
Is the patient currently taking any drugs/medications? _____ No _____ Yes
If yes please list: _____
Does the patient have any allergies? _____ No _____ Yes
If yes please list: _____
Has there ever been an adverse reaction to latex or nickel? _____ No _____ Yes
Does the patient need antibiotics before seeing the dentist? _____ No _____ Yes

Please circle any of the following conditions that the patient has had or now has:

Congenital Heart Lesions	Anemia	Epilepsy/Seizures	Jaw/Facial injuries
Heart Murmur	HIV/AIDS	Fainting Spells	Dental/Tooth Injuries
Rheumatic Fever	Hepatitis	Asthma	Frequent Headaches
Tuberculosis	Kidney Problems	Mouth Breathing	Clenching/grinding of teeth
Persistent Cough	Liver Problems	Speech Problems	Ringing in the ears
Abnormal Bleeding	Stomach ulcers	Canker Sores	Sinus Trouble
High/Low Blood Pressure	Mental Disorders	Jaw Locking	Smoke/Chew tobacco
Cancer	Heart Disease	Glaucoma	Arthritis
Allergies	Thyroid problem	Diabetes	Pregnant Now?
Sore Facial Muscles			

Please explain conditions from above as needed: _____
_____

Do you have any medical or dental problems not listed above? _____ No _____ Yes
Please explain: _____

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Orthodontist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such Orthodontic care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the Orthodontist insurance payments otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby give Dr. Ewing and Team permission to confirm appointments using the phone number(s) I have provided, to include leaving messages

_____Date_____
Signature Patient/Parent/Guardian

I verbally reviewed the medical/dental information above with the Patient/Parent/Guardian.
Signed: _____ Date: _____

EWING ORTHODONTICS

739 President Place Ste 210
Smyrna, TN 37167
615-220-8585

Financial Statement

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for this account to be turned over for collection, I am responsible for any collection and/or attorney fees.

Insurance Statement

I authorize the release of any information needed to process my child's insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

Disappointment Fee

I understand it is my responsibility to give the doctor at least a 24 hour notice if I am unable to keep my child's appointment. In the event that I do not give the 24 hour notice or do not call and do not show up, the doctor reserves the right to charge a $25 cancellation fee. This will compensate for the time he had reserved to treat my child and was unable, due to lack of notice, to schedule another patient for treatment during that time.

Authorization

I hereby authorize and acknowledge that any scanned/electronic signatures are to be considered an original signature.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge that I have received or rejected Notice of Privacy Practices from the office of Ewing Orthodontics.

Signature of Parent/Guardian:_____Date:_____