Benjamin F. Lowe, Jr., DDS, MS
Orthodontics for Children & Adults

Welcome to Our Office

Please Print

Member American Association of Orthodontists

Patient's Name:_____ Preferred Name:_____ Birthdate:_____ Sex:___

Home Address:_____ Home Phone:_____
Street City State Zip Code

Patient's General Dentist:_____ Last Visit to Dentist:_____

IS THERE SOMEONE OTHER THAN YOUR DENTIST WHOM WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? (FRIENDS, NEIGHBORS, PATIENTS, ETC.?)

Information For Patients Who Are MINORS:

Age:_____ Grade:_____ School:_____

Interests:_____

What is the child's attitude towards: Brushing_____ Dentistry_____ Orthodontics_____

Mother's Name:_____ Father's Name:_____ Guardian's Name (if diff.)_____

Parents' Marital Status: ❑ Married ❑ Separated ❑ Widowed ❑ Divorced (if divorced, who has custody of child?_____)

Responsible Party Information (to be completed by all adult patients and the parent/guardian of patients who are minors)

Responsible Party #1_____ Relationship to patient:_____

Home Address_____
Street /PO Box City County State Zip Code

SS#:_____ DOB:_____ Home Phone:_____ Cell Phone:_____

Employer:_____ Occupation:_____ Work Phone:_____

Dental Insurance? (y/n)_____ Orthodontic Insurance? (y/n)_____ Insurance Co.:_____

Responsible Party #2_____ Relationship to patient:_____

Home Address:_____
Street /PO Box City County State Zip Code

SS#:_____ DOB:_____ Home Phone:_____ Cell Phone:_____

Employer:_____ Occupation:_____ Work Phone:_____

Dental Insurance? (y/n)_____ Orthodontic Insurance? (y/n)_____ Insurance Co.:_____

MEDICAL HISTORY

Name & Address of patient's physician_____

Is the patient in good health? ❑ Yes ❑ No If No Please Explain:_____

Any serious accidents, operations, or unusual illnesses: ❑ Yes ❑ No Explain:_____

Currently under physician's care? ❑ Yes ❑ No If Yes Please Explain:_____

Allergies? ❑ Yes ❑ No List:_____

Drug Sensitivity? ❑ Yes ❑ No List:_____

Does the patient have an artificial heart valve, a history of endocarditis, any other serious congenital heart condition (including heart transplant) or any other medical condition that requires being premedicated with antibiotics prior to dental treatment? ❑ Yes ❑ No (If yes, please explain_____)

Does the patient take (or have they ever taken) a bisphosphonate drug such as Fosamax, Boniva, Actonel, etc. that is used to treat osteoporosis or other bone disorders? ❑ Yes ❑ No

Does the patient use non-steroidal anti-inflammatory drugs (NSAIDS) such as Ibuprofen/Advil, Naproxen, Relafen, etc. on a daily basis? ❑ Yes ❑ No

Please indicate whether or not the patient has or had any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Arthritis	❑	❑	Asthma	❑	❑	Frequent Cold/Flu	❑	❑	Mental Retardation
❑	❑	Anemia	❑	❑	Kidney Problems	❑	❑	Tonsilitis	❑	❑	Nervous Disorder
❑	❑	Bleeding Problems	❑	❑	Liver Problems	❑	❑	Hepatitis	❑	❑	Emotional Problems
❑	❑	Heart Disease	❑	❑	Endocrine Problems	❑	❑	Tuberculosis	❑	❑	Learning Disability
❑	❑	High Blood Pressure	❑	❑	Epilepsy/Seizures	❑	❑	HIV/AIDS	❑	❑	Speech/Hearing Problems
❑	❑	Rheumatic Fever	❑	❑	Diabetes	❑	❑	Herpes	❑	❑	Glaucoma

Growth/Family History Information For Patients Under 18 Years of Age

Child's Height:_____ Father's Height:_____ Mother's Height:_____

Patient Resembles: ❑ Neither Parent ❑ Mother ❑ Father

Girls: Has she started menstruation? ❑ No ❑ Yes Age: _____

Boys: Has his voice changed? ❑ No ❑ Yes Age: _____

Is there any family history of a strong lower jaw and/or underbite? ❑ No ❑ Yes

Names and Ages of Patient's Brothers and Sisters? _____

Have any had Orthodontic Treatment? ❑ No ❑ Yes When? _____

DENTAL HISTORY

YES	NO	
❑	❑	Is the patient currently in orthodontic treatment? Name & address of orthodontist:_____
❑	❑	Has the patient consulted an orthodontist previously? Name & address of orthodontist:_____
❑	❑	Has the patient ever had gum disease?_____ Treatment?_____
❑	❑	Has the patient had any severe head or face injuries? Explain:_____
❑	❑	Has the patient had a history of thumb sucking or finger sucking? _____ Stopped? _____ When?_____
❑	❑	Does the patient play any musical (wind) instruments? _____ What?_____
❑	❑	Have you ever been informed of missing or extra permanent teeth?_____
❑	❑	Does the patient's jaw ever get "stuck" or "locked" or have difficulty opening his/her mouth?
❑	❑	Do the patient's jaw joints ever "pop" or make noise? How often?_____
❑	❑	Does the patient have jaw joint pain? How often? _____
❑	❑	Has the patient previously been treated for jaw joint ("TMJ") problem?

Why are you seeking orthodontic consultation?_____

_____

Is there any other information which may be helpful? _____

Please read the following regarding our financial policies:

In separation/divorce situations, the individual who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services. Even when another party or estranged spouse is billed, the person initiating treatment is ultimately responsible should the other party fail to pay.

Please note that our office is very willing to help out with the filing of insurance and, in most cases, we will file the primary insurance for you and accept the assignment of benefits. In the case of secondary insurance, we will gladly assist you in filing it but due to the uncertainty of secondary coverage, our office policy is to have secondary insurance benefits paid to the patient.

In the event of a denied insurance claim, we will do our best to help you work things out with the insurance company but any insurance dispute is ultimately between the insured and the insurance company. If a claim remains unpaid despite our good faith effort to file it, the responsible party is ultimately responsible for payment of the entire account balance - including that part not paid by the insurance company.

I have read and understand the financial policies listed above.

Signed_____ Date_____