Katherine M. Lambert, D.M.D.

Practice Limited to Orthodontics

Patient Information

Date____/____/____

Patient Name _____Nickname_____
First Middle Last

If Patient is Child, Parents Name_____

Address_____
Street City State Zip Code

Home Phone (___)_____ Work Phone (___)_____ Cell Phone(___)_____

Sex: M F Age_____ Date of Birth _____/_____/_____ Grade in School _____

Dentist_____ Physician_____

Who Referred you to our practice? _____

Hobbies/Interests? _____

Patient Health History

Does the patient have or ever had:

Rheumatic Fever ___ Mental Disorders ___ Diabetes ___ Bleeding Tendency ___

Heart Condition ___ Speech Problems ___ Anemia ___ Epilepsy ___

Heart Murmur ___ Hepatitis ___ Allergies ___ HIV ___

Latex Allergy? _____Other_____

Are you currently taking any medications?_____

Are you or could you be pregnant?_____

Do you have any brothers and sisters?_____ Ages _____

In your own words, please describe the orthodontic problem as you see it. _____

_____

_____

Does anyone else in the family have a similar dental or facial condition?_____

If so please describe._____

Has anyone else in the family received orthodontic care? Yes___No___

If yes, was the patient treated in this office? Yes___No___

Have the teeth of the patient ever been injured? Yes___No___

What was the cause of the accident? _____

_____

How old was the patient at the time of accident? _____***Which teeth were involved?*** _____

If the patient has any of the following habits please check:

Mouth Breather _____ Finger or Thumb Sucking _____ Grinding _____

Tongue Thrusting _____ Lip Biting or Sucking _____ Nail Biting _____

Other _____

Has the patient had any unfavorable experiences at a dental or medical office?_____

If yes, please explain _____

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Primary Responsible Party Information

Responsible Party Name_____

First Last

Address_____

Street City State Zip Code Apt#

Home Phone (___)_____ Cell Phone (___)_____

Date of Birth _____/_____/_____ SSN_____-_____-_____

Email Address_____

Dental Insurance Company_____

Group #_____ Member # _____

2nd Responsible Party Name_____

First Last

Address_____

Street City State Zip Code Apt#

Home Phone (___)_____ Cell Phone (___)_____

Date of Birth _____/_____/_____ SSN_____-_____-_____

Email Address_____

Dental Insurance Company_____

Group #_____ Member # _____

We would like to welcome you to our office. Please see the next page for important information.

We are pleased to welcome you to our office today for your initial consultation where our goal is to provide you with an evaluation and answer your questions about orthodontics and general

treatment options. Please understand there is only so much we can "see" by looking in your mouth and there may be a recommendation to do "diagnostic records" — these records will allow the doctor to fully understand, accurately diagnose and prepare a specific treatment plan. (Diagnostic records may consist of x-rays, diagnostic study models and/photos; note, not all records are taken in each patient's case.) If you consent to diagnostic records being taken, there will be a corresponding charge.

I have read, understand and accept that if diagnostic records are taken, there will be a corresponding charge. Further, I understand that I will be responsible for these charges, regardless of insurance coverage.

_____ _____

Signature of Responsible Party **Date**

(must be 18 or older to sign)

*If you have insurance, and we are submitting on your behalf, *half* (50%) the charges will be due today.

*If you do **not** have insurance, or do not want us to submit on your behalf, *all* (100%) charges will be due today.

*Please direct any questions to our front desk concerning charges for diagnostic records.

WOULD YOU LIKE US TO SUBMIT AN INSURANCE CLAIM FOR TODAY'S VISIT?

YES _____ NO_____

I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE.

_____ _____

Signature of Responsible Party Date