Koglin Orthodontics

James W. Koglin, D.D.S

ORTHODONTIC MEDICAL AND DENTAL CASE QUESTIONNAIRE

NAME:_____ I prefer to be called:_____ D.O.B.:_____

Address:_____ Telephone: Home:_____

Cell phone:_____ Work phone:_____ E-Mail:_____

Spouse's Name:_____ Please Circle Marital Status: M S D W

Dental Insurance :_____ Insured's Name:_____ D.O.B:_____

Employer Name:_____ Group number:_____ I.D. number:_____

Insurance Company Address:_____ Phone number:_____

Dentist:_____ City:_____ Physician:_____ City:_____

Are any of your teeth in pain? Yes or No
Do you have or have you ever had gum disease? Yes or No
Have you had previous orthodontic treatment? Yes or No
Have you had any major falls, accidents or operations? Yes or No
Are you presently being treated by a physician? Yes or No
Have you been hospitalized during the last two years? Yes or No
If so, for what_____
Any difficulty breathing through your nose? Yes or No
Any difficulty swallowing or chewing? Yes or No
Any clicking or pain when you open or close your mouth? Yes or No

Do you have or have you had any of the following: Please underline if yes to any of these.

Rheumatic fever	Chickenpox	Repeated headache	Drug Allergry (penicillin,aspirin, etc)	
Convulsions	Measles	Repeated Sore Throats	Heart Disease	Hemophilia
Diabetes	Mumps	Repeated colds	Broken Bones	Hepatitis
Tuberculosis	Pneumonia	Asthma	Blood diseases	HIV Positive
Polio	Anemia	Hay fever	Heart murmur	Food Allergy

What concerns you most about your teeth?_____

Were you considering braces, Invisalign or retainer(s)? Circle all that apply.

How did you hear about us?_____

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PRIVACY NOTICE ACKNOWLEDGMENT

I hereby acknowledge that have received a copy of Notice of Privacy Practices for Koglin Orthodontics.

_____	_____	_____
Patient Name	Signature	Date

☐ Check her is patient is a minor and sign below

☐ Check here if you are the patient's legal Representative (other than a parent) sign below

and state relationship with the patient : _____

_____	_____	_____
Name of Parent or Legal Guardian	Signature	Date

Cell Phone Use Policy:

1. I provide consent to Koglin Orthodontics to use my cell phone number to call or leave text messages regarding appointments.

2. I consent to Koglin Orthodontics to call using my cell phone regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My Cell phone number is (include area code) _____ Initial _____

THIS SECTION TO BE COMPLETED BY KOGLIN ORTHODONTICS PERSONNEL

Check Applicable situation below if acknowledgment was not obtained at the time of first delivery of service.

☐ In Emergency treatment situations, we will attemp to obtain acknowledgment of receipt of Privacy Notice as soon as practicable after the delivery of such treatment.

☐ Other (describle efforts to attempt to obtain acknowledgment and explain why acknowledgment was not obtained.

_____	_____
Signature	Date