Bancroft Dobrin Orthodontics

JAMES J. BANCROFT, DMD
SPECIALTY PERMIT #3319
ASHLEY BANCROFT-DOBRIN, DMD, MBA
SPECIALTY PERMIT #06510
KEITH R. DOBRIN, DMD, MBA
SPECIALTY PERMIT #06556

Date _____

Patient Information

Patient Name _____ Current Dentist _____
Nickname _____Gender _____ Dentist Phone #_____
Birthdate _____ Age _____ Physician _____
Address _____
City, State, Zip_____ Referred by _____
Home Phone: _____
Cell #: _____
E-mail: _____
Confirmation Preference: ☐ Text ☐ E-mail ☐ Phone Call

Employer _____
Occupation _____
Work Number _____Ext_____
Marital Status (circle one): Single / Married / Divorced / Widowed / Separated

Spouse

Name _____ Phone # _____
Employer _____ Occupation _____
Work # _____Ext _____

Orthodontic Insurance

Insurance Company _____ Insurance Co. phone # _____
Insurance Co. Address _____
Suscriber's Name _____
Relationship _____ Birthdate _____ Soc. Sec. # _____
Group # _____ ID # _____

For office use only - Please continue to next page

Molar Class: Cl I End-on Cl II Full-step Cl II Super Cl I Cl III N/A
Canine Class: Cl I End-on Cl II Full-step Cl II Super Cl I Cl III N/A
Condition: Crowding Spacing Overbite:_____ Overjet:_____ Impactions
Treatment: Comprehensive Tx Limited Tx
Modality: Twin Damon Ceramic Invisalign

CONFIDENTIAL

Dental & Health History

Your overall health as well as any medications, which you may take, could have an important interrelationship with the dental care you receive. Please answer the following questions completely.

How often do you brush? _____ How often do you floss? _____

Is your water fluoridated?	Yes No
Do you take fluoride supplements?	Yes No
Do you:	
Suck thumb/finger	Yes No
Suck/Bite lip	Yes No
Bite/Chew nails	Yes No
Chew hard objects	Yes No
Grind teeth	Yes No
Clench jaws	Yes No

Have you had difficulty with previous dental visits? _____

Do you have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? _____

Do you have a latex allergy or any other allergy?

_____

Are you currently taking any medications? Yes No (If yes, please list)

_____

Have you ever had any of the following: (if yes please explain below)*

Abnormal Bleeding	Yes No	Asthma	Yes No
Cancer	Yes No	Congenital heart Defect	Yes No
Convulsions/Epilepsy	Yes No	Diabetes	Yes No
Handicaps/Disabilities	Yes No	Heart Murmur	Yes No
Hemophilia	Yes No	Hepatitis	Yes No
HIV/AIDS	Yes No	Hypertension	Yes No
Rheumatic Fever	Yes No	Stomach/liver/kidney problems	Yes No
Tuberculosis	Yes No		

*Please explain any medical problems that you have: _____

_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I also authorize this dental staff to perform the necessary dental services I may need. I also authorize Dr. Bancroft to release any information including the diagnosis and the records of treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Bancroft otherwise payable to me. I understand that my 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 dependents.

_____ _____

Signature of patient Date