KAUAI ORTHODONTICS

Dr. Timothy R. Agee DMD MS

Patient's Name: ______________________________ Nickname: _____________________ Date of Birth:____________________

Address: ___________________________________ City: __________________________ Zip: ___________________________

Home Phone: ______________________ Parent's Cell Phone: _____________________ Child's Cell Phone: ________________

☐ Male

☐ Female School: ____________________________________ Grade:_____

Emergency Contact: _____________________ Phone Number: _____________________ Relationship: ________________________

Father's Name: _________________________
Employer: ____________________________
Business Phone: ________________________
Cell Phone: ____________________________
Billing Address: ________________________
City: ______________ Zip: ________
SSN: _________________________________

Parent's Marital Status
S M W D

Mother's Name: __________________________________
Employer: ______________________________________
Business Phone: _________________________________
Cell Phone: _____________________________________
Billing Address: _________________________________
City: ______________ Zip: __________________
SSN: ___________________________________

Person Responsible for Account: _________________________ Billing Phone: _______________________________

Patient's Dentist: ____________________ Referred By: _____________________ Patent's Physician: ____________________________
Please describe the patient's problem or desired outcome: ____
____

MEDICAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF:

- 1)HEART TROUBLE/MURMUR
- 2)HIGH BLOOD PRESSURE
- 3)RHEUMATIC FEVER
- 4)STROKE
- 5)BLEEDING DISORDER
- 6) FREQUENT HEADACHE
- 7) DIZZINESS/FAINTING
- 8) THYROID DISORDER
- 9)KIDNEY DISORDER
- 10) LIVER DISORDER
- 11) SINUS DISORDER
- 12) ALLERGIES/HIVES
- 13) DIABETES
- 14) ARTHRITIS
- 15) TUBERCULOSIS (TB)
- 16) EPILEPSY
- 17) STOMACH DISORDERS
- 18) ANEMIA
- 19) CANCER
- 20)HEPATITIS
- 21) RESPIRATORY DISORDER
- 22) ASTHMA
- 23) PSYCHOLOGICAL DISORDER
- 24) TONSIL/ADENOID PROBLEM
- 25) SPEECH DISORDER

YES NO 26) HAS THE PATIENT BEEN UNDER A PHYSICIAN'S CARE IN THE LAST 2 YEARS?
YES NO 27) HAS THE PATIENT HAD ANY SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION?
YES NO 28) IS THE PATIENT TAKING ANY DRUGS OR MEDICATIONS?
YES NO 29) HAS THE PATIENT BEEN DIAGNOSED WITH OSTEOPOROSIS, OSTEOPENIA OR TAKEN BISPHOSPHONATES?

DENTAL HISTORY

YES NO 30) HAS THE PATIENT HAD ANY TRAUMATIC INJURIES TO THE FACE, MOUTH, OR TEETH?
YES NO 31) DOES THE PATIENT HAVE A HISTORY OF THUMB OR FINGER SUCKING?
YES NO 32) DOES THE PATIENT HAVE A HISTORY OF LIP OR CHEEK BITING?
YES NO 33) DOES THE PATIENT HAVE A HISTORY OF CHRONIC MOUTH BREATHING?
YES NO 34) DOES THE PATIENT HAVE A HISTORY OF GRINDING OR CLENCHING THEIR TEETH?

GROWTH HISTORY

YES NO 35) DOES ANY MEMBER OF THE FAMILY HAVE A SIGNIFICANT UNDERBITE OR PROMINENT LOWER JAW?
YES NO 36) FEMALE ONLY- HAS THE PATIENT STARTED HER MONTHLY PERIOD? IF YES, WHEN? _______ IS THE PATIENT PREGNANT? YES NO
37) WHAT IS THE HEIGHT OF THE PATIENT? _________ HEIGHT OF PATIENT'S MOTHER? _______ HEIGHT OF THE FATHER? _______

⚪YES ⚪NO 38) HAVE ANY RELATIVES OR CLOSE FRIENDS BEEN A PATIENT IN OUR PRACTICE?

PLEASE ELABORATE ON ANY CHECKED ITEMS FROM ABOVE:

____

____

ORTHO INSURANCE COMPANY:

PRIMARY INSURANCE COMPANY NAME: ____________________________SUBSCRIBER'S NAME:____

SUBSCRIBERS ID# OR SS#: ___________________________ GROUP NUMBER: ____

SECONDARY INSURANCE COMPANY NAME: ____ SUBSCRIBER'S NAME: _____________________________________

SUBSCRIBERS ID# OR SS#: _____________________________________ GROUP NUMBER: ____

As a courtesy to our patients, we will submit any necessary insurance claims provided that we have been informed of the current insurance coverage and have all necessary information needed to process the claim. The patient/parent/guardian will be responsible for any uncovered insurance portion.

I________________________________ (patient/parent/guardian), authorize the release of any necessary information for submission of any insurance claim.

____

Signature Printed name Relationship Date

Sometimes records- (xrays, study models or diagnostic photographs) are necessary to complete the examination. If so, we will inform you prior to taking any records and we will give you an estimated cost.

I hereby authorize Timothy R. Agee, D.M.D. MS, to perform an orthodontic examination and take necessary records

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Signature Printed name Relationship Date