Joseph A. Sweet, D.M.D., P.C.

PRACTICE LIMITED TO ORTHODONTICS

Adult Patient Information Todayôs Date _____

Patientôs name_____ SS#_____ Sex____ DOB_____ Age_____

Patientôs Full Address_____
City Zip

Home Phone_____ Cell Phone_____ E-Mail_____

Employer _____ Occupation _____ Work #_____

Employerôs Address _____

Names of Relatives Treated Here_____

Personal Dentistôs Name_____

Whom may we thank for referring you to our office?_____

Information on spouse or other authorized party to make payments on or inquire about your account.

Name_____ Relationship to you_____ S.S.#_____ DOB_____

Occupation_____ Employerôs Address _____Work#_____

Primary Insuredôs Name_____ SS#_____ Ins Co._____

Group # _____ Local#_____ Ins. Co. Phone #_____

Insurance Co. Address _____

Has any deductible been met? Y/N Is Insured Signature on file? Y/N Does patient have dual Coverage? Y/N

2nd Insuredôs Name_____ SS#_____ Ins Co. _____

Group # _____ Local# _____ Ins. Co. Phone #_____

Has any deductible been met? Y/N Is Insured Signature on file? Y/N Does patient have dual Coverage? Y/N

Insurance Information

We will be happy to assist you in filing your insurance claim. However, all payments are the responsibility of the responsible party, and an account will not be put on hold awaiting insurance benefits.

We do not accept no fault insurance.

Record Release Authorization

I consent to the examination and treatment of _____by Joseph A. Sweet, D.M.D and his staff. I authorize Joseph A. Sweet, D.M.D. to release any and all of the named patientôs dental record, including but not limited to; records of office visits and treatment rendered, x-rays, x-ray reports and photographs. Such records may be released to another dentist or orthodontist, or any other health care professional, for the purposes of discussing or consulting said patientôs condition. These records may also be released to any governmental agencies, insurance companies, employees of insurance companies, any managed care organizations which contract my insurer for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to the named patient, or performing quality assurance reviews as required by law. This authorization shall remain in effect for 15 years from the below signed date.

_____ _____ _____

Signature of Patient Print Name Date

Clinical Examination

For office use only

PATIENT EXAM NOTES DATE_____

CHIEF CONCERNS

_____

_____

_____

R Class_____L Class_____

OB _____% OJ_____

Midlines: Max._____ Mand._____

ARCH LENGTH

MAX: Crowding Spacing WNL

Slight Moderate Severe

MAND: Crowding Spacing WNL

Slight Moderate Severe

OTHER NOTES:

_____

BOLTON:_____

HABITS:_____

TMJ: _____

DISCUSSION:

_____

_____

RECORDS TAKEN

IMAGES PAN CEPH MODELS

BITEWINGS