Moss & Brannan ORTHODONTICS

Dr. Robert B. Moss, Jr., DMD ~ Dr. Catharine Moss Brannan, DMD

Tell Us About Yourself: Date: _____

Patient's Name:_____
(First) (Middle) (Last) (Nickname)

S.S.#:_____ Date of Birth :_____ Age: _____ Circle One: Male / Female

Patient's Address:_____

_____ _____ _____
(City) (State) (Zip Code)

Contact Numbers: Home_____Cell_____Work_____

Employer: _____ Occupation: _____

Our office uses an automated system for confirming all appointments. What is the best text # and email to use?

_____ _____
(Text) (Email)

What is your main concern that you want addressed by the orthodontist? _____
Have you ever seen an orthodontist before today? Yes or No
If so, have you had any previous orthodontic treatment? _____
Who can we thank for referring you to this office?_____
Are there other family members that have been seen in our office?_____

**Please list below all parties you wish to place on your account. Please understand anyone listed below is being granted full disclosure to financial and treatment information on file as designated below. If there are any specific privacy restrictions please inform our office!!!*

Name:_____ Date of Birth: _____
S.S. #:_____ Cell #: _____
Employer:_____ Work#: _____
Relation: _____ Email: _____

INSURANCE INFORMATION

Policy Holder: _____ Telephone#: _____
Policy Holder DOB:_____ S.S.#: _____
Policy Holders Address: _____
Employer: _____ Employer Phone #:_____
DENTAL Insurance Carrier: _____
Insurance Telephone #: _____
DENTAL Claim Address:_____

_____ _____ _____
(City) (State) (Zip Code)

Member ID#:_____ Group#: _____

Insurance: Our office files insurance as a courtesy for our patients. We cannot file your insurance without a copy of your insurance card. If you do not have a copy of your card, please contact your Human Resources Department for the following information: Policy holder's name as written on the card, name & address of the insurance company, phone number of the insurance company, Member ID# & the Group ID #.

Doctor initial: _____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Dentist: _____ Last Cleaning Date: _____

Physician: _____

PLEASE CIRCLE THE FOLLOWING AS THEY APPLY: **Is the patient pregnant: YES or NO**

Allergies (Drug / Latex / Metals):_____

ADD	Diabetic	Heart Disease	Periodic MRI/CT Scans
ADHD	Diagnosed Syndromes	Heart Murmur	Previous Orthodontics
Anemia	Difficulty Breathing	Heart Surgery/Pacemaker	Previous TMJ Therapy
Abnormal Bleeding	Drug / Alcohol Abuse	Hemophilia	Prophylactic Antibiotics
Anxiety	Emphysema	Hepatitis	Psychiatric Problems
Arthritis	Emotional Problems	HIV/AIDS	RadiationTreatment
Asthma	Epilepsy	Jaw/Joint Noise	Rheumatic / Scarlet Fever
Blood Pressure (High / Low)	Facial Tooth Injury	Jaw Locking	Shingles
Blood Transfusion	Fever Blisters / Herpes	Kidney Problems	Sickle Cell Disease / Traits
Cancer / Chemotherapy	Frequent Headaches	Liver Disease	Sinus Problems
Chewing Problems	Glaucoma	Mitro-Valve Prolapse	Thumb Habits
Congenital Heart Defect	Gum Disease	Missing Teeth	Tuberculosis (TB)
Contact Lenses	Grinding of Teeth	Multiple Sclerosis (MS)	Ulcers / Colitis
Depression	Heart Attack / Stroke	Osteoporosis (Fosamax)	Venereal Disease

Please explain in detail any health issues and list all medications currently taken (including non-prescription drugs):

_____

_____

***I understand that the information that I have provided today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

Signature:_____ Date: _____

FAMILY SMILES EST 1989
Moss & Brannan
ORTHODONTICS

Do you have a social media account that you would like for us to follow?
If so, Let us know your account names below:

_____

**Be sure to follow us @moss.brannan.ortho and like our Facebook Page
so you can learn about ongoing contests and fun things around the office