

WELCOME TO OUR ORTHODONTIC OFFICE
ARTHUR L. KAPIT, D.D.S., M.Sc.D., P.A.

PATIENT INFORMATION

Patient Name: _____ Today's Date _____

Sex ___ Age ___ Date of Birth _____ Home Phone# _____ School _____ Grade _____

Address _____

Street

City

State

Zip

E-MAIL ADDRESS (Needed to Confirm Appointments) _____

CHILD'S HEALTH INFORMATION

Dentist 's Name: _____ Address: _____ Phone# _____

Has child ever had any complications following dental treatment? ___yes ___no

If yes please explain: _____

Physician's Name: _____ Address: _____ Phone# _____

Has child been admitted to a hospital or needed emergency care during the past year? ___yes ___no

If yes please explain: _____

Is child now under the care of a physician? ___yes ___no If yes please explain: _____

Is child now taking any medication? ___yes ___no If yes please explain: _____

Please list any behavioral or developmental disorders _____

Has child ever had any of the following? Please check those that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS or HIV positive | <input type="checkbox"/> Blood/Bleeding disorder | <input type="checkbox"/> Heart Disease/Surgery | <input type="checkbox"/> Eye Disease |
| <input type="checkbox"/> Allergies: Sulfa Drugs | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur/Rheum. Fever | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Problems/Ulcer | <input type="checkbox"/> Mental/Nervous Disorder |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Hepatitis (Liver Disease) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma/Resp. Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors/Growth |
| <input type="checkbox"/> Arthritis/Joint Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Glandular/Hormonal Dis. |

Does child have any health problems that need further clarification or any other contributory family medical history? ___yes ___no

If yes please explain: _____

Emergency contact other than child's parents: Name _____ Phone# _____ Relationship _____

ORTHODONTIC HISTORY (ALL SPACES MUST BE FILLED IN – WRITE n/a IF NOT APPLICABLE)

Who recommended us to you? _____

Chief complaint (your purpose for seeking treatment) _____

Has your child seen another orthodontist? ___yes ___no If yes, who? _____

Has any member of your family had or been treated for an orthodontic problem? _____

If a musical instrument is played, what kind? _____

Gingival infection or treatments? _____ Traumatic injury to teeth? _____

Does your child grind their teeth? ___yes ___no ___Day ___Night

Any finger or tongue habits? _____ Age stopped _____

Child's attitude toward braces: ___ Good ___ Bad ___ Indifferent

Please list any other family members who are patients of this office _____

Siblings in orthodontic treatment _____

PARENT'S INFORMATION

Who will pay this account? _____ Relationship to patient _____
Mother: Full Name _____ FATHER: Full Name _____
Address (if diff from child) _____ Address (if diff from child) _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Phone: Home _____ Work _____ Phone: Home _____ Work _____
Occupation _____ Occupation _____
Employer _____ Employer _____
Work address _____ Work address _____
City _____ St _____ Zip _____ City _____ St _____ Zip _____
Mother's Social Security # _____ Father's Social Security # _____
Driver's license # _____ Driver's license # _____
Parent's marital status: Married Separated Divorced Widowed Single Custodial parent

DENTAL INSURANCE INFORMATION

Are you aware of the extent of your insurance coverage for orthodontics? _____

Primary: Name of insured: _____ is insured a patient? yes no

Insured's birth date: _____ ID# _____ Group # _____

Insured's address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name _____

Address _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Child Other _____

Insurance plan name and address _____ Ins. Co. phone# _____

Secondary: Name of insured: _____ is insured a patient? yes no

Insured's birth date: _____ ID# _____ Group # _____

Insured's address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name _____

Address _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Child Other _____

Insurance plan name and address _____ Ins. Co. phone# _____

AGREEMENT FOR DENTAL SERVICES

1. The parent/legal guardian or guarantor hereby retains Dr. Arthur L. Kapit to render orthodontic services to and for your child's benefit.
2. The parent/legal guardian or guarantor hereby agrees to pay for all the bills and charges for services provided promptly. The charges are due at the time service is rendered.
3. The parent/legal guardian or guarantor acknowledges that he/she is responsible for all charges incurred in the rendering of dental services, regardless of what type of insurance he/she carries. Any action by this office to process applications for insurance or other benefits on your behalf will not relieve you of the obligation to pay the bill. The parent/legal guardian or guarantor further understands that any failure by the insurance company or other provider of benefits to pay for all or part of your bill will not excuse the obligation to pay the entire amount for services rendered. Our office will make every effort to assist you in filing and processing your claim.
4. In the event that this office finds it necessary to resort to collection action due to an unpaid bill, the parent/legal guardian or guarantor agrees to pay all costs, expenses, and attorney's fees with collection.
5. Accounts that are delinquent over thirty days will be charged a finance charge of 1.5% per month.
6. Since your child is a minor, it is necessary to obtain your permission before any necessary dental service can be rendered. Authorization is hereby granted. **NO TREATMENT OR ANESTHESIA WILL BE PERFORMED WITHOUT YOUR PRIOR KNOWLEDGE AND CONSENT.**

Date _____ Relationship to child _____

Signature of parent/legal guardian/guarantor _____