519 N. 17th Avenue
Wausau, WI 54401
(715) 842-5459

Hovda Orthodontics

www.hovdaorthodontics.com

109B S. Center Avenue
Merrill, WI 54452
(715) 536-1339

PATIENT INFORMATION

Last Name	First Name	Nickname	SS No.	Sex	Birth Date	Age

Mailing Address	City	State	Zip	Home Phone

School (if student)	Grade	[ ] Single [ ] Married [ ] Sep [ ] Divorced [ ] Widow(er)	Employed by/Occupation	Business Phone

Email	Fax	Cell Phone

Who may we thank for recommending us?	Name of Dentist	Date of Last Visit

Related patients that are or have been under our care	Names & ages of other children	
1	1	3
2	2	4

PARENT INFORMATION (please complete if patient is a minor)

Father's Name ______________________

Address (if different from patient's) ______________________

____

City ____________ St ______ Zip ______

Home Phone ____________ Work Phone ____________

Cell Phone ____________ Email ____________

S.S. No. ____________ D.O.B. ____________

Employer ______________________

Address ______________________

City ____________ St ______ Zip ______

Mother's Name ______________________

Address (if different from patient's) ______________________

____

City ____________ St ______ Zip ______

Home Phone ____________ Work Phone ____________

Cell Phone ____________ Email ____________

S.S. No. ____________ D.O.B. ____________

Employer ______________________

Address ______________________

City ____________ St ______ Zip ______

Parent's Marital Status

❑ Single ❑ Married ❑ Divorced ❑ Widowed

If divorce is involved, who is the custodial parent?

____

Stepmother's Name ______________________
(if applicable)

Stepfather's Name ______________________
(if applicable)

May the patient information be released to the non-custodial parent?

❑ Yes ❑ No

Other individuals, please list:

1. ______________________ Relationship ____________

2. ______________________ Relationship ____________

ORTHODONTIC INSURANCE INFORMATION

Primary Insurance Information

Policyholder's Name ______________________

SS # ____________ Subscriber ID # ____________

DOB ______________________

Place of Employment ______________________

Group # ______________________

Insurance Co. Name ______________________

Mailing Address for Claims ______________________

____

Contact Phone # ______________________

Secondary Insurance Information

Policyholder's Name ______________________

SS # ____________ Subscriber ID # ____________

DOB ______________________

Place of Employment ______________________

Group # ______________________

Insurance Co. Name ______________________

Mailing Address for Claims ______________________

____

Contact Phone # ______________________

– over –

MEDICAL HISTORY	DENTAL HISTORY
Please check if patient has or has had	**Please check Yes or No**

Medical History — Please check if patient has or has had

[Y] [N]

[ ] [ ] Joint swelling
[ ] [ ] Bone disorders
[ ] [ ] Heart trouble
[ ] [ ] Mitral valve prolapse
[ ] [ ] Pre-med needed
[ ] [ ] Rheumatic trouble
[ ] [ ] Thyroid problems
[ ] [ ] Diabetes
[ ] [ ] Emotional problems
[ ] [ ] Brain injury
[ ] [ ] Kidney or liver involvement
[ ] [ ] Joint prosthesis

[Y] [N]

[ ] [ ] Tuberculosis
[ ] [ ] Anemia
[ ] [ ] Epilepsy (convulsions)
[ ] [ ] Prolonged bleeding
[ ] [ ] Faintness/Dizziness
[ ] [ ] Tonsils removed
[ ] [ ] Adenoids removed
[ ] [ ] Sore throats
[ ] [ ] Tonsillitis
[ ] [ ] Earaches
[ ] [ ] Arthritis

On items checked "Yes," please provide us with a more detailed description:

Dental History — Please check Yes or No

[Y] [N]

[ ] [ ] Any injuries to face, mouth, teeth? (circle)
[ ] [ ] Thumb, finger, lip sucking? (circle)
[ ] [ ] More than average amount of decay?
[ ] [ ] Any missing permanent teeth?
[ ] [ ] Any extra permanent teeth?
[ ] [ ] Any teeth removed by extraction?
[ ] [ ] Any difficulty in swallowing or chewing?
[ ] [ ] Any pain or clicking on opening mouth?
[ ] [ ] Is patient adopted? At what age? ______
[ ] [ ] Does patient visit dentist regularly? Date of last visit _____________
[ ] [ ] Has an orthodontist been consulted previously?

Any other information that may be helpful:

Approximately how much has patient grown in the last year?

What would you like to have orthodontic treatment accomplish?

List any other serious illnesses:

List any allergies:

List drugs or medications now being taken:

Is patient presently under physician's care?

Reason:

Name of physician:

Primary: Other:

Other: Other:

Patient's attitude toward orthodontic treatment:

(circle one) Very motivated Will cooperate if needed Not motivated

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be taken for diagnostic purposes. I agree to be responsible for charges not covered by my dental benefit plan. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Who is responsible for account? Relationship

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent.

________________________ ____

Date Signature of Patient, or Parent or Guardian if Patient is a Minor

Updates (date & initial) ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________ , have received a copy of this office's Notice of Privacy Practices.

Signed (Patient, or Parent if minor)

For Office Use Only Acknowledgement could not be obtained because:

❑ Refusal to sign ❑ Communication barriers were prohibitive ❑ Other: ______________________