



Welcome To Our Office!

Ryan A. Boyer DDS MSD
Specialist in Orthodontics

PATIENT INFORMATION

Date _____

Name: _____ Home Phone #: _____
First Middle Last Nickname
Address: _____ City State Zip
Email: _____ Birthday: _____ Age: _____ Sex: ☐ M ☐ F
Employer: _____ Work #: _____ Occupation: _____
Best Time to Reach You: _____ Cell #: _____
☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed Spouse's Name & Number: _____
Referred By: _____
In Case of an Emergency, Call (Name & Number) : _____
Other Family Members Seen By Us: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
Billing Address: _____
Home Address if different: _____
Home/ Cell #: _____ DL #: _____
Employer: _____ Wk #: _____
SS#: _____ Birthdate: _____

MEDICAL INFORMATION

Physician: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO		YES	NO
Are You Under the Care of a Physician:			Hospitalized For Any Reason:		
Are You in Good Health:			Kidney Problems:		
Abnormal Bleeding:			Pacemaker:		
Alcohol/ Drug Abuse:			Psychiatric Problems:		
Anemia:			Radiation Treatment:		
Arthritis:			Rheumatic Fever/Scarlet Fever:		
Artificial Bones, Joints/Valves:			Any Seizure Disorder:		
Asthma or Hay Fever:			Sickle Cell Disease/Traits:		
Blood Transfusions:			Sinus Problems:		
Cancer/ Chemotherapy:			Stroke:		
Colitis:			Thyroid Problems:		
Any Heart Disease/Defects:			Tuberculosis:		
Diabetes:			Ulcers:		
Difficulty Breathing:			Venereal Disease:		
H.I.V. Positive/AIDS:			Allergic to Latex / Metals:		
Any High or Low Blood Pressure:			Ever taken Fosamax, or any other bisphosphonate?		
A History of Fainting or Dizziness:			For Women:		
Heart Murmur:			Are you using a prescribed method of birth control?		
Hemophilia:			Are you pregnant?		
Hepatitis/Liver Problems:			Week #		
Handicaps/Disabilities/Hearing Impairment:			Are you nursing?		
Herpes/Fever Blisters:					

Please discuss any medical problems that you have: _____

List Any Medications or Supplements Currently Taking: _____

Are You Allergic to Anything, if so what: _____

Any other disease, condition, or problem not listed above that we should know about: _____

DENTAL HISTORY

Dentist: _____ Phone #: _____ Date of Last Visit: _____

	YES	NO		YES	NO
Have You Been Evaluated or had Orthodontic Treatment Before:			Thumb/Finger Sucking:		
Have You Seen a General Dentist in the Last Year:			Mouth Breather:		
Has Your Mouth, Face or Teeth Been Injured by a Fall or Accident:			Finger Nail Biting:		
Frequent Headaches:			Tongue Thrusting:		
Are You Aware of Any "Gum" Problems:			Clench/Grind Teeth:		
Have You Had Tonsils or Adenoids Been Removed:			Speech Problems:		
Know of Any Missing or Extra Permanent Teeth:			Smoke or Use Tobacco Products:		
Pain/Clicking/Popping in Jaw Joint (TMD/ TMJ):			Currently in Any Pain:		
Require Antibiotics Before Dental Treatment:			Do You Like Your Smile:		
Have You Ever Had Serious Problem With Any Previous Dental Work:			Brush Twice a Day:		
			Floss: ☐ Every Day ☐ Some Days ☐ Never		

In Your Own Words What is the Orthodontic Problem: _____

DENTAL INSURANCE

Primary Dental Insurance

Secondary Dental Insurance

Insured's Name #1 _____	Insured's Name #2 _____
Soc. Sec. # of Insured _____	Soc. Sec. # of Insured _____
Birthdate of Insured _____ / _____ / _____	Birthdate of Insured _____ / _____ / _____
Employer _____	Employer _____
Insurance Company _____	Insurance Company _____
Insurance Company Phone # (_____) _____	Insurance Company Phone # (_____) _____
Insurance Company Address _____	Insurance Company Address _____
Insurance Group # _____	Insurance Group # _____

I hereby authorize release of any information to other health care providers, insurance companies and business associates including personal health information, as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment of insurance benefits directly to Ryan Boyer Orthodontist.

I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

I certify that the information on this form is complete and true to the best of my knowledge. I also understand that this information is held in the strictest confidence and it my responsibility to inform the office of any changes in my medical status. I understand that when appropriate, credit bureau reports may be obtained.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

Signature _____

Date _____

This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

****** Please note that some longer procedures are only done in the mornings during school hours ******

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