N. Daniel Ranjbar D.D.S., P.A.

Practice Limited to Orthodontics

Member American Association of Orthodontists

PATIENT INFORMATION

Patient: _____ Date of Birth: _____ Age: _____ Sex: _____

Street Address: _____ City, State and Zip Code: _____

Home Phone: _____ School: _____

Dentist: _____ Medical Doctor: _____

Whom may we thank for referring you? _____

Family Members treated at this office: _____

Siblings and ages _____(__) _____(__) _____(__)

Primary Responsible Party: _____ Relationship to Patient: _____

Social Security Number: _____ E-Mail: _____

Address: _____ Cell Phone: _____

Correspondence by text? Yes ☐ No ☐

Home Phone: _____ Daytime Phone: _____ Occupation: _____

- In order to provide the best possible payment plan options, I hereby authorize Ranjbar Orthodontics to obtain a copy of my credit report from OrthoBanc, LLC and/or a credit reporting agency. (**Please initial Yes or No→**) ____ Yes ____ No
- I authorize this office to disclose information regarding the patient to a family member, friend or other person to the extent necessary to help with the patient's healthcare or payment for their healthcare. (**Please initial Yes or No→**) ____ Yes ____ No
- Please exclude the following persons from receiving any information regarding treatment or finances: _____

ORTHODONTIC INSURANCE INFORMATION:

Policy Holders Name: _____ Relationship to Patient: _____

Date of Birth: _____ Daytime Phone: _____ Social Security: _____

Policy Holders Address (if different): _____

Ins. Co. Name: _____ ID # on Insurance Card: _____

Employer or Group Name: _____ Insurance Phone: _____

Insurance Address: _____

PLEASE SIGN THE FOLLOWING TWO RELEASES FOR BILLING INSURANCE:

Assignment of Benefits:
I hereby authorize payment directly to the Provider for services rendered.

_____
Signature of Parent or Guarantor

Release of Information:
I hereby authorize the release of any dental information necessary to process this claim.

_____
Signature of Parent or Guarantor

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WELCOME TO OUR OFFICE!

Patient's Name: _____

	YES	NO
Is the patient in good health?……..	_____	_____
Is the patient under the care of a physician?……...	_____	_____
If yes, explain and list name of medication:_____		
_____		
Does the patient require antibiotic coverage for dental work?……	_____	_____
Does the patient have a history of:		
Allergies……..	_____	_____
Asthma……	_____	_____
Sinus Infection……	_____	_____
Drug Allergies……	_____	_____
Heart Trouble…….	_____	_____
HIV Virus (AIDS)……..	_____	_____
Diabetes……..	_____	_____
Hepatitis, Jaundice…….	_____	_____
Glandular Disorders……	_____	_____
Any other illness or recurrent disease…….	_____	_____
If yes, explain: _____		
_____		

Please check any oral habits the patient may have or have had previously:

Thumb Sucking	_____	Clenching of Teeth	_____
Finger Sucking	_____	Lip Biting	_____
Mouth Breathing	_____	Nail Biting	_____
Grinding of Teeth	_____	Tongue Thrusting	_____

Comments:_____

Does patient have a history of trauma or injury to face, jaw area, or permanent teeth?	_____	_____
If yes, list and describe:_____		
_____		
Has the patient had any previous orthodontic treatment?	_____	_____
If yes, explain_____		
_____		

Responsible Party Signature: _____ Date: _____