

PATIENT INFORMATION . Adult

Name: _____ Date: _____

Name patient prefers to go by: _____ Telephone #: () _____

Date of Birth: _____ Age: _____ Gender (Check appropriate box): Male Female

Home address _____

Interests/Hobbies: _____

Physician: _____ Dentist: _____

Whom may we thank for referring you to our office? _____

Names of family members treated here: _____

Marital Status of parents (Check appropriate box): Single Married Divorced
 Widowed Separated Remarried

Do you have dental insurance that covers orthodontics? Yes No

Have you used any of the coverage? Yes No S.S.# _____

Employer: _____ Work () _____ Cell _____

Work Address: _____

Spouse's name: _____ S.S.# _____

Employer: _____ Work () _____ Cell _____

Work Address: _____

Name of nearest relative not living with you: _____

Relationship to Patient: _____ Telephone #: () _____

Why are you seeking orthodontic treatment (concerns)?

(If you desire our office to file insurance please fill out ALL insurance information on the next page).

INSURANCE INFORMATION—Please fill out all information

If you desire our office to file insurance for you, please fill out **ALL** of the following information. **Our office will file your primary insurance.** If you have more than one insurance we will provide you with a superbill containing information that is needed in order for you to receive secondary benefits. **Please note that most insurance carriers require an Explanation of Benefits** that you receive back from your primary insurance carrier in order to process your secondary insurance. When we verify your insurance benefits, the information quoted is not a guarantee of payment and final determination will be made when insurance is filed. **If your primary insurance does not pay the projected amount obtained by our office then that amount will be applied to the patient's personal account for the responsible party to pay.**

Today's Date: _____ Patient's Name: _____ DOB: _____

PRIMARY INSURANCE COVERAGE INFORMATION:

Name of Insured: _____

Birthdate of Insured: _____ Insured's Social Security #: _____

Relationship to Patient: ___Father ___Mother ___Spouse ___Self

Place of Insured's Employment: _____

Insurance Company Name: _____

Insurance Company Address: _____

Telephone # of Insurance Co.: (_____) _____

Fax #: _____ Group #: _____ Policy #: _____

Signature permission for our office to file your insurance

Dr. Stroop's office has permission to file orthodontic insurance that will be paid to his office: _____ **Date:** _____

Insured's Signature

Date: _____ Verified By: _____ Spoke With: _____ Effective Date: _____

Ortho Coverage: Yes: ___ No: ___ Reason For No Coverage: _____

Plan Maximum: \$ _____ Plan Deductible: _____ Recertification Date: _____

*per yr. ___ *per tx. ___ Met this yr? Yes ___ No ___

Deductible year starts: calendar yr. ___ or date _____

Ortho Benefit Pays At _____ % Pays: Monthly ___ Quarterly _____ AUTO

Is Billing Necessary? Yes ___ No ___ Initial Placement Pays \$ _____ or _____ %

Any EXCLUSIONS to this policy (age limits): _____

Claims Address: _____

Pays Provider _____ Pays Subscriber _____ Amount of Ins. Used \$ _____

HEALTH HISTORY

Patient's Name: _____ Date: _____

Please indicate which of the following applies by checking the box or if none apply choose NONE THAT I KNOW OF

- | | | |
|-----------------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> NONE THAT I KNOW OF | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Head / Facial Injury |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease / Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> HIV (Aids) |

Is the Patient allergic to:

<u>(Please check Yes or No)</u>	Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Tylenol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Advil	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other (please list): _____

1. Is the patient taking any medication(s), including non-prescription medicine? Yes No
If Yes please indicate: _____
2. Does the patient have any general allergies? Yes No
If Yes please indicate: _____
3. Has the patient had any psychological counseling? Yes No
4. Does the patient wear contact lenses? Yes No
5. Have tonsils / adenoids been removed? Yes No
If Yes what age: _____
6. For X-ray purposes are you pregnant? Yes No

DENTAL HISTORY

- | | | |
|-----------------------------------------------------------|------------------------------|-----------------------------|
| Have there been injuries to the face, mouth, or teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the patient ever sucked a thumb/finger? Age: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient breathe predominately through the mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient have any speech problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has patient had clicking or discomfort in jaw joints? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient clench or grind their teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the patient apprehensive toward dental treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient want orthodontic treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the patient have any congenital abnormalities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been informed of any MISSING permanent teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been informed of any EXTRA permanent teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has parent/other children had orthodontic treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| When did patient last see dentist? _____ | | |

Complete only for patients 18 years and younger:

Height: Patient: _____ Father: _____ Mother: _____
Patient most resembles: Father Mother Both

Signature of person completing this form: _____

Date: _____ Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse To Sign This Acknowledgement

I, _____,
patient's: mother, father, guardian, the patient, other
_____ (please circle relationship), have received
a copy of Dr. Stroop's notice of privacy practices for the
patient listed below.

Please Print Patient's Name

Date of Acknowledgement

Responsible Party Signature

Date of Acknowledgement

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ **Individual refuses to sign**

_____ **Communications barrier prohibited obtaining the acknowledgement**

_____ **An emergency situation prevented us from obtaining acknowledgement**

_____ **Other (please specify) _____**

**Directions to the office of
Dr. John R. Stroop, D.M.D.
644 Cherokee Street – Marietta 30060
770-422-8502**

From I-75: Exit at 267B (Hospital exit). The exit ramp only goes in one direction. When you get off the ramp you will need to stay in the far-left lane. Go another 0.7 miles through the three traffic lights, then turn left onto Margaret Street just past the hospital. Go 0.1m to Cherokee Street Turn left onto Cherokee street. Go 350ft and you will see our sign "Stroop Orthodontics" on the right.

From Stilesboro: Turn right onto old Hwy. 41. Follow Old 41 until it dead ends into Church Street Extension. Follow Church Street Extension down to the traffic light. At the traffic light turn right onto Church Street. Go approximately 0.7 miles through the three traffic lights and turn left onto Margaret St, just past the hospital. Go 0.1m to Cherokee St. Turn left onto Cherokee street. Go 350ft and you will see our sign "Stroop Orthodontics" on the right.

From the Marietta Square: Follow Cherokee Street down just past Margaret Street and just before Cherry Street. You will see our sign on the right side of the street, "Stroop Orthodontics".

WELCOME TO OUR ORTHODONTIC OFFICE

Meet Dr. Stroop

Dr. Stroop has been in practice for 29 years.

His best friend is his wife Kathy.

He has two children. Jonathan is 29 years old and Nikki is 26 years old.

He likes to golf and water ski.

He grew up in Tennessee and Kentucky.

His favorite book is the Bible. He is active in his church.

Now, please tell him about You:

My name is _____

You can call me _____

Favorite things to do _____

Favorite sport(s) _____

Favorite music _____

Other _____