PATIENT INFORMATION ï Child

Name: _____ Date:_____

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

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

Responsible Party Name: _____
* In divorce cases it is our office policy to have the parent that brings the child for appointments to be responsible for the bill.

Responsible Party Address: _____

Responsible Party City, State, Zip: _____

Responsible Parties e-mail:_____
(Appointment reminders will be sent to this to this email address)

Interests/Hobbies: _____

Grade: _____ School: _____

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

If divorced patient lives with: ☐ Mother ☐ Father ☐ Other: _____

Fatherôs name: _____ SS #_____

Employer: _____ Work ( ) _____Cell_____

Work Address: _____

Motherôs 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)?
_____

Do you have dental insurance that covers orthodontics? ☐ Yes ☐ No
(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, ñthe information quoted is not a guarantee of paymentò and ñfinal determination will be made when insurance is filedò. **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.**

Todayôs Date:_____Patientôs Name:_____DOB:_____

PRIMARY INSURANCE COVERAGE INFORMATION:

Name of Insured:_____

Birthdate of Insured:_____Insuredôs Social Security #:_____

Relationship to Patient: ___Father ___Mother ___Spouse ___Self

Place of Insuredôs Employment:_____

Employerôs Address:_____

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

☐	**NONE THAT I KNOW OF**	☐	Blood Disease	☐	Blood Disorder
☐	Anemia	☐	Kidney Disease	☐	Hearing Disorder
☐	Asthma	☐	Liver Disease	☐	Head / Facial Injury
☐	Arthritis	☐	Excessive Bleeding	☐	Rheumatic Fever
☐	Diabetes	☐	Endocrine Disorder	☐	Rheumatic Heart Disease
☐	Epilepsy	☐	High Blood Pressure	☐	Heart Disease / Problems
☐	Hepatitis	☐	Sinus Problems	☐	HIV (Aids)

Is the Patient allergic to:	Aspirin	☐ Yes	☐ No
(Please check Yes or No)	Tylenol	☐ Yes	☐ No
	Advil	☐ Yes	☐ No
	Penicillin	☐ Yes	☐ No
	Latex	☐ Yes	☐ 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?	☐ Yes	☐ No
Has the patient ever sucked a thumb/finger? Age: _____	☐ Yes	☐ No
Does the patient breathe predominately through the mouth?	☐ Yes	☐ No
Does the patient have any speech problems?	☐ Yes	☐ No
Has patient had clicking or discomfort in jaw joints?	☐ Yes	☐ No
Does the patient clench or grind their teeth?	☐ Yes	☐ No
Is the patient apprehensive toward dental treatment?	☐ Yes	☐ No
Does the patient want orthodontic treatment?	☐ Yes	☐ No
Does the patient have any congenital abnormalities?	☐ Yes	☐ No
Have you been informed of any MISSING permanent teeth?	☐ Yes	☐ No
Have you been informed of any EXTRA permanent teeth?	☐ Yes	☐ No
Has parent/other children had orthodontic treatment?	☐ Yes	☐ 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: _____

WELCOME TO OUR ORTHODONTIC OFFICE

Meet Dr. Stroop

He likes for patients to call him Dr. Stroop. He 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_____

I have _____ brother(s) and _____ sister(s).

Favorite things to do _____

Favorite sport(s)_____

Favorite music_____

Best Friend_____

Favorite pet_____

Other _____

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 ñStroop Orthodonticsò 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 ñStroop Orthodonticsò 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, ñStroop Orthodonticsò.