

"Welcome to our office! Every patient is given a specific treatment plan catered precisely to them. Going over and above the standard of care is our standard of care." - Kyle Kuzmic D.D.S., M.S.

Personal II	nformation	
Today's Date / /	,	
Patient's Name		
(Last)	(Fir	, , ,
Nickname	_ DOB/	/
Ageyrs	□Male	□Female
Patient's Phone		
Patient's Address		
(City)	(State)	(Zip)
School/Job Title		
Hobbies / Sports		
Siblings with Age		
Pt's General Dentist		
How did you hear about us	s?	
Person Accom	<u>panying Min</u>	<u>or</u>
Name		
(Last)	(First)	(MI)
Relationship to Patient		
Do you have legal custody		
Parent's Marital Status	\Box Single	□ Married
\Box Divorced \Box	Widowed	□ Separated
		1
Mother's I	<u>nformation</u>	
□stepmother □ guardian		/
Full Name	<u> </u>	,
Phone (cell)	(work)	
Employer		o. Years
Job Title		0. 1 curs
Father's Ir	<u>nformation</u>	
		/
\Box stepfather \Box guardian	DOB/	/
Full Name	(1)	
Phone (cell)	(work)	
Employer	N	o. Years
Job Title		
	ev Contact	

Relative or Neighbor NOT living with you:	
Full Name	
Daytime Phone	
E-mail	

Full Name			
Relationship to Patient			
Billing Address			
(City)	(State)	(Zip)	
Phone (home)	(work)		
Employer	No. Years		
		• • •	

Person Responsible for Account

Person Responsible for Making Appointments Full Name

Phone (cell)	(work)
E-mail	

<u>Orthodontic Ins</u>	irance	
Orthodontic Coverage?] Yes	🗆 No
Insurance Co. Name		
Insurance Co. Address		
Insurance Co. Phone		
Group # (Plan/Local or Policy #	<u>+</u>)	
Policy Owner's Name		
Relationship to Patient		
Policy Owner's DOB	/	/
SSN		
Employer		
Do you have dual coverage? Orthodontic Coverage? Insurance Co. Name Insurance Co. Address Insurance Co. Phone Group # (Plan/Local or Policy # Policy Owner's Name Relationship to Patient Policy Owner's DOB SSN Employer] Yes	No If Yes: □ No

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Questions?	Fax: (317) 846-4390
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\bigcirc	Website: www.kuzmicortho.com

Medical Information

Indicate YES if you currently have or have ever had any of the following medical conditions, explain on right

Heart Disease	□ Yes □ No	Mononucleosis	🗆 Yes 🗆 No	
	\Box Yes \Box No		\Box Yes \Box No	
Respiratory Disease Blood Disease	\Box Yes \Box No	Hepatitis Polio		
			\Box Yes \Box No	
Liver Disease	\Box Yes \Box No	Diabetes	\Box Yes \Box No	
Thyroid Disease	\Box Yes \Box No	Emphysema	\Box Yes \Box No	
Kidney Disease	\Box Yes \Box No	Epilepsy	\Box Yes \Box No	
Venereal Disease	\Box Yes \Box No	Nervous/Emotional Problems	\Box Yes \Box No	
Intestinal Disease	\Box Yes \Box No	High/Low Blood Pressure	\Box Yes \Box No	
Bone Disease	\Box Yes \Box No	Problems with Wound Healing	\Box Yes \Box No	
Endocrine Disease	\Box Yes \Box No	Rheumatic/Scarlet Fever	\Box Yes \Box No	
HIV Positive	\Box Yes \Box No	Rheumatism or Arthritis	\Box Yes \Box No	
Blood Transfusion	\Box Yes \Box No	Frequent Headaches	\Box Yes \Box No	
Tumors or Cancer	\Box Yes \Box No	Sexually Transmitted Illness	\Box Yes \Box No	
Asthma or Hay Fever	\Box Yes \Box No	Is Patient Under Medical Care	\Box Yes \Box No	
Tuberculosis	\Box Yes \Box No	History of Fainting/Dizziness	\Box Yes \Box No	
Any Broken Bones	\Box Yes \Box No	Drug Addiction	\Box Yes \Box No	
Prolonged Bleeding	\Box Yes \Box No	Is Patient Pregnant	\Box Yes \Box No	
Yellow Jaundice	\Box Yes \Box No	Is Patient a Smoker	\Box Yes \Box No	
Radiation Therapy	\Box Yes \Box No	Oral Herpes	\Box Yes \Box No	
Chemical Therapy	\Box Yes \Box No	Canker Sores	\Box Yes \Box No	
Patient's Physician		Phone		Date of Last Visit
If female, Has Menstrua	tion begun? \Box Yes	Age \Box No Is the Patient cur	rrently taking any	medications? \Box Yes \Box No
Please list all medication	s, including dosage			
Is the Patient allergic to	any medications?	□ Yes □ No If yes, please list		
Please indicate or list an	v other allergies:	□ Latex □ Nickel □ Other		
Please list any previous	surgeries and date			
, , , , , , , , , , , , , , , , , , ,	her disease/condition	on/problem not listed above that we	should know abou	t? □ Yes □ No
Are vou aware of any of				

Dental History

ly Type of Toothbrush:	Electric Manual
uent/None Water Flosser?	\Box Yes \Box No
□ Yes □ No	
\Box Yes \Box No	
□ Yes □ No	
□ Yes □ No	
\Box Yes \Box No	
\Box Yes \Box No	
	uent/None Water Flosser? □ Yes No □ Yes No

Does the Patient Have or Ever Had Any of the Following Habits? \Box Thumb/Finger Sucking \Box Tongue Thrust \Box Nail Biting \Box Lip sucking/biting \Box Mouth breathing \Box Speech Problems \Box Gum Chewing (Daily) \Box Grinding Teeth \Box Ice Chewing

Has the Patient been evaluated or treated by an orthodontist before? Evaluated Treated Where	_
Has anyone else in your family been seen by Dr. Kuzmic or Dr. Stoner? Name(s):	
In Your Words, What is the Orthodontic Problem?	

I understand that the information given is correct and will be held in the strictest confidence, and that it is my responsibility to inform Kuzmic Orthodontics of any changes in the patient's above information.