WELCOME

To the office of Dr. Scott L. Kesselman, D.D.S
Riverside Orthodontics

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you.

Patient Information

Mr. Mrs. Ms. Miss Dr. Other: _____ Todays Date: ____/____/____

Patient Name: _____
First **Middle** **Last** **(Name Called)**

Birthdate: ____/____/____ Age: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____)_____-_____ Work Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Social Security #: _____-____-_____ School **or** Employer: _____

E-Mail: _____@_____.com Emergency Contact & Phone: _____

Financial Information

Mr. Mrs. Ms. Miss Dr. Other: _____

Responsible Party: _____ Marital Status: _____
First **Middle** **Last**

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security #: _____-____-_____ Birthdate: ____/____/____ Relationship to Patient _____

E-Mail: _____@_____.com Employer: _____

Please circle one choice below

The financial party above agrees to pay in full at the time of the patients' appointment: Cash Check Visa MasterCard American Express

Second Person Information

Mr. Mrs. Ms. Miss Dr. Other: _____

Responsible Party: _____ Marital Status: _____
First **Middle** **Last**

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security #: _____-____-_____ Birthdate: ____/____/____ Relationship to Patient _____

E-Mail: _____@_____.com Employer: _____

(OVER)

Dental Insurance Information

Subscriber's Full Name: _____ Birthdate: ____/____/____

Subscriber's Mailing Address: _____ City: _____ State: _____ Zip code: _____

Subscriber's Social Security #: ____-____-____ Insured's ID #: _____ Insured's Group #: _____

Primary Dental Insurance Company: _____ Insurance Phone: (____)____-____

Primary Insurance Address: _____

I hereby authorize Dr. Kesselman's office to submit all Insurance, as a courtesy, on my behalf. I acknowledge that I am responsible for the costs incurred at the time of service.
Please be aware that it is your responsibility as the patient/guardian to inform us when your insurance company changes.

You must fill out this section completely along with a copy of your card, in order to have us file your Insurance for you.

Medical Information

Who referred you to our practice?: _____ Regular Dentist: _____

Have you ever received orthodontic treatment? Yes No Explain: _____

Have you ever been treated for Periodontal or TMJ problems? Yes No Explain: _____

Have you ever experienced an unfavorable reaction to dental treatment? Yes No Explain: _____

Physician: _____ Known Medical Problems: _____

Allergies: _____ Medication: _____

Accidents: _____ Any major illness, or hospitalization: _____
(medical or dental)

Diabetes	HIV Virus	Heart Murmur	Tuberculosis
Heart Trouble	Rheumatic Fever	Hepatitis / Liver Problems	Prolonged Bleeding
Anemia	High Blood Pressure	Arthritis	Endocrine Problems
Bone Disorder	Fainting or Dizziness	Seizure/ Epilepsy	Asthma

For younger female patients; When did menses begin?: _____ Women: are you pregnant? Yes No

Social Information

Favorite Hobbies, Sports, Interests: _____

Habits such as Finger Sucking or Nail Biting: _____

Describe your child's temperament: _____

Sibling Information

Sibling name: _____ Birthdate: ____/____/____ Any orthodontic problems? Yes No

Sibling name: _____ Birthdate: ____/____/____ Any orthodontic problems? Yes No

Sibling name: _____ Birthdate: ____/____/____ Any orthodontic problems? Yes No

To the best of my knowledge the information above is accurate and complete. I authorize Dr. Kesselman and/or staff to provide dental treatment and I agree to be responsible for expenses incurred. I understand it to be my responsibility to inform this office of any medical changes.

Signature _____ Date _____ Relationship _____