# WELCOME TO OUR OFFICE

TODAY'S DATE:\_

PATIENT'S NAME	MALE FEMALE			_	
ADDRESS (ST)		CITY, STATE, ZIP			DO YOU (
HOME PHONE	CELL PH #/CARRIER	PATIENT'S S.S.# (IF ADU	JLT)		HEPATITIS
					ALLERGY
PLACE OF EMPLOYMENT (IF ADULT)	WORK PHONE	SCHOOL NAME			ALLERGY
					ALLERTY
SPECIAL INTERESTS	WHAT (IF ANY) MUSICA	L INSTRUMENT IS PLAYE	D?		DIABETES
					EPILEPSY
IF MINOR,	, COMPLETE THE FO	LLOWING:			ASTHMA
FATHER'S NAME		ADDRESS (ST.)			BREATHIN
		ADDITEOD (01.)			HAY FEVE
HOME PHONE	CELL PH #/CARRIER	CITY, STATE, ZIP			SINUS PR
		,,			HEART CO
OCCUPATION		WHERE EMPLOYED			BLEEDING
					OSTEOPO
WORK PHONE		FATHER'S S.S.#			ORAL OR TREATME
MOTHER'S NAME MRS. M	S.	ADDRESS (ST.)		- i	KIDNEY P
		. ,			REACTION
HOME PHONE	CELL PH #/CARRIER	CITY, STATE, ZIP			REACTION
					NERVE PF
OCCUPATION		WHERE EMPLOYED			BACK OR
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WORK PHONE		MOTHER'S S.S.#			ANY COM
	DDONTIC COVERAGE IS A Insured D.O.B.		WBER		COMMEN HAVE YOU
NAME OF INSURANCE CO. IF ORTHO NAME OF INSURED WOULD YOU LIKE TO RECEIVE YOUF D PHONE D EMAIL OR D T	INSURED D.O.B.	SOCIAL SECURITY NU	MBER		ARE YOU COMMEN HAVE YOU COMMEN
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When answered by			than patient, "You" refers to patient.		
DO YOU OR HAVE YOU EVER HAD:	MED	ICAL	HISTORY		
DO TOU ON HAVE TOU EVEN HAD.	YES	NO		YES	NO
HEPATITIS/LIVER PROBLEMS		NO	BIRTH DEFECTS	120	110
ALLERGY TO PENICILLIN			MEASLES		
ALLERGY TO LATEX			MUMPS		
ALLERTY TO NICKEL/METALS			CHICKEN POX		
DIABETES			SPEECH PROBLEMS		
EPILEPSY/SEIZURES			SWALLOWING PROBLEMS		
ASTHMA			FAINTING		
BREATHING PROBLEMS			EYE DISORDER		
HAY FEVER/ALLERGIES			GLASSES/CONTACTS		
SINUS PROBLEMS			GLAUCOMA		
HEART CONDITIONS/MURMUR			ULCERS/COLITIS		
BLEEDING PROBLEMS/ANEMIA			HIV/AIDS		
OSTEOPOROSIS			PHYSICAL HANDICAP		
ORAL OR IV BIOPHOSPHONATE			MENTAL HANDICAP		
TREATMENT			TUBERCULOSIS		
KIDNEY PROBLEMS			HIGH BLOOD PRESSURE		
REACTION TO DRUGS			RHEUMATIC FEVER		
REACTION TO ANESTHETIC			EATING DISORDER		
NERVE PROBLEMS			ADD/ADHD		
BACK OR NECK PROBLEMS			TONSILS/ADENOIDS REMOVED		
MAJOR SURGERY			TAKING MEDICATIONS NOW		
ANY COMMENTS ON ANY OF THE ABO	OVE OR OI	N OTH	ER HEALTH MATTERS YOU WOULD LIKE	US TO K	NOW
ARE YOU NOW UNDER THE CARE OF COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS:					
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS:	LIZATION	IS? Y		VEC	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD:	LIZATION DEN	IS? Y	YES D NO D	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR	LIZATION DEN	IS? Y	YES D NO D	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH?	DEN FACE?	IS? Y	YES D NO D	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE	DEN DEN FACE?	IS? Y TAL   ?	YES NO D	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS	DEN DEN FACE?	IS? Y TAL   ?	YES NO D	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY?	DEN DEN FACE?	IS? Y TAL   ?	YES NO D	YES	NO
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COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY?	LIZATION DEN FACE? ATMENT? T THERAF	IS? Y <b>TAL</b> ? PY, OR	YES NO HISTORY	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO PA	LIZATION DEN FACE? ATMENT? T THERAF	IS? Y <b>TAL</b> ? PY, OR	YES NO HISTORY	YES	NO
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COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OF ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS?	DEN FACE? ATMENT? AST MEDI	S? Y TAL I PY, OR CAL C	YES NO NO HISTORY	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OF ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI HAS ANY NEAR RELATIVE EVER HAI	DEN FACE? ATMENT? ATMENT? AST MEDI	TAL I TAL I PY, OR CAL C OR JA	YES INO INCLOSED         HISTORY         HISTORY         R MYOFUNCTIONAL THERAPY?         IR DENTAL CARE?         IN SURGERY?         LE RECEEDING OR PROTUDING	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OF ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI HAS ANY NEAR RELATIVE EVER HAI LOWER JAW?	DEACE?	S? Y TAL I ? PY, OR CAL C OR JA CEABL	INTERNATIONAL THERAPY?	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OF ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI LOWER JAW? HAS ANYONE IN THE FAMILY HAD O	DEACIAL DEACE?	S? Y TAL I ? PY, OR CAL C OR JA CEABL NTIC 1 (ES:	INTERNATIONAL THERAPY?	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI LOWER JAW? HAS ANYONE IN THE FAMILY HAD O DO YOU SUCK YOUR FINGER OR TH	DEACE? ATMENT? T THERAF AST MEDI D FACIAL D A NOTIO RTHODOI JMB? IF Y DR THUME	S? Y TAL I ? PY, OR CAL C CEABL NTIC 1 (ES: B?	YES       NO         HISTORY         HISTORY         R MYOFUNCTIONAL THERAPY?         R DENTAL CARE?         DR DENTAL CARE?         WY SURGERY?         LE RECEEDING OR PROTUDING         TREATMENT?         INIGHT AND/OR       DAY	YES	NO
COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO PA FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI LOWER JAW? HAS ANYONE IN THE FAMILY HAD O DO YOU SUCK YOUR FINGER OR THI DO YOU EVER SUCK YOUR FINGER OR	DEACIAL DANOTIC DEACIAL DANOTIC RTHODO JMB? IF Y DR THUMI DE OF YO	S? Y TAL I ? PY, OR CAL C OR JA CEABL OR JA CEABL NTIC 1 YES: B? UUR CF	YES       NO         HISTORY         HISTORY         R MYOFUNCTIONAL THERAPY?         OR DENTAL CARE?         OR DENTAL CARE?         WW SURGERY?         E RECEEDING OR PROTUDING         TREATMENT?         INIGHT AND/OR       DAY         HEEK?	YES	NO
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COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OR ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI LOWER JAW? HAS ANYONE IN THE FAMILY HAD O DO YOU SUCK YOUR FINGER OR THI DO YOU EVER SUCK YOUR FINGER OR THI DO YOU BITE OR SUCK ON THE INSI DO YOU BITE YOUR FINGERNAILS O	DEACE?	S? Y TAL I PY, OR CCAL C OR JA CEABL NTIC 1 (ES: B? UR CF OBJE GHT A	YES       NO         HISTORY         HISTORY         R MYOFUNCTIONAL THERAPY?         R DENTAL CARE?         W SURGERY?         E RECEEDING OR PROTUDING         TREATMENT?         NIGHT AND/OR       DAY         HEEK?         CT?         ND/OR       DAY	YES	NO
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COMMENTS: HAVE YOU HAD ANY PAST HOSPITA COMMENTS: DO YOU OR HAVE YOU EVER HAD: ANY PAST INJURY TO THE HEAD OF ANY PAST INJURY TO TEETH? ANY PREVIOUS ORTHODONTIC TRE SPEECH THERAPY, TONGUE THRUS ANY TOOTH SENSITIVITY? BLEEDING GUMS? AN UNFAVORABLE REACTION TO P/ FREQUENT MOUTH ULCERS? ANY PREVIOUS EXTRACTIONS? RECENT DENTAL X-RAYS? HAS ANY NEAR RELATIVE EVER HAI LOWER JAW? HAS ANY NEAR RELATIVE EVER HAI LOWER JAW? HAS ANYONE IN THE FAMILY HAD O DO YOU SUCK YOUR FINGER OR THI DO YOU EVER SUCK YOUR FINGER OF DO YOU BITE OR SUCK ON THE INSI DO YOU BITE OR SUCK ON THE INSI DO YOU BITE YOUR FINGER AT HOMI DO YOU GET FLUORIDE TREATMENT HAVE YOU EVER HAD PERIODONTAL HAVE YOU EVER HAD PERIODONTAL HAVE YOU EVER HAD A ROOT CANA DO YOU FREQUENTLY CHEW CHEW	LIZATION FACE? ATMENT? T THERAF AST MEDI D FACIAL D FACIAL D FACIAL D A NOTIC RTHODOI JMB? IF Y DR THUMI DE OF YO R OTHER S: INIC S:	S? Y TAL I ? PY, OR CAL C OR JA CEABL OR JA CEABL NTIC 1 YES: B? UR CH OBJE GHT A IGHT A IGHT A TREA ?	/ES INO I         HISTORY         HISTORY         R MYOFUNCTIONAL THERAPY?         IN DENTAL CARE?         IN DENTAL CARE?         IN BUR DENTAL CARE?         IN BUR DENTAL CARE?         IN SURGERY?         IE RECEEDING OR PROTUDING         IR TREATMENT?         INGHT AND/OR IDAY         INGHT AND/OR IDAY         AND/OR IDAY         OR FROM YOUR DENTIST?         IMENT?	YES	NO



3 Baden Powell Lane, Suite 2 Mechanicsburg, PA 17050 (717) 691-3550 1412 Bridge Street New Cumberland, PA 17070 (717) 774-1200 4509 Union Deposit Rd. Harrisburg, PA 17111 (717) 558-9808

Mark J. Kearns, D.D.S., M.S. | Taylor J. Lamb, D.M.D., M.S. | Damian K. Mariano, D.M.D., M.S.

mklortho.com

## **Patient Responsibilities and Insurance Information**

Patient Name\_

We look forward to providing you and/or your children with the best orthodontic treatment available. We realize that in order to achieve outstanding results it requires a team effort between our doctors, staff, and the patient. In many cases the patient's parents/guardians play a very important role as well.

#### Appointment Scheduling:

When scheduling orthodontic appointments, it is our intent to make every effort possible to accommodate your schedule. Due to the nature of our services, many of our patients are of school age. Early morning and late afternoon appointments are available, but limited. These times are scheduled on a first come first served basis. In order to accommodate as many patients as possible during these hours we try to limit longer appointments to other times throughout the day. We appreciate your help and understanding in upholding this policy.

#### **Insurance and Payment:**

Before the start of treatment you will be presented with an orthodontic diagnosis, a detailed treatment plan, treatment time estimates, treatment fees, and payment options. Ultimately you, the receiver of orthodontic services, are responsible for payment of services provided. Should your financial account become delinquent we have the right to request payment in full or discontinue treatment at our discretion.

We will work with you and your insurance carrier to ensure you get the maximum orthodontic benefits available towards your treatment. Please provide our business office with your insurance information so we can help you determine the amount of benefits available and how those benefits will be disbursed. Your orthodontic benefits will be sent directly to you in your name. We will submit all pertinent information to your insurance carrier in order for you to receive your full benefits. Orthodontic insurance may be different than your general dental benefits where payments go directly to the dentist office.

### Method of Payment:

We accept cash, Visa, MasterCard, Discover, American Express and check or money order payable to *MKL Orthodontists*. Once you have been presented with your treatment plan and fee you will have payment plan options with our office or with *Lending Club Financing*.

I acknowledge that I have read and understand the above information and I give MKL Orthodontists permission to submit to my insurance carrier any/all information that they deem necessary.

Date: \_\_\_\_\_

Patient signature: