DARCY C. CRUIKSHANK, DMD, MSD, LLC
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SPECIALISTS IN ORTHODONTICS

*Today's Date*________________________

Patient's First Name	Middle Initial	Last Name	Nickname	Date of Birth	Age	Gender

Patient's Dentist	Referred By

Orthodontic Insurance Carrier	Insurance Phone Number	Medical Savings Plan?

Who is financially responsible for this account?____

Patient's marital status? Married______Separated________Divorced________Domestic Partnership_______Widow(er)_______Remarried_______

Please complete the following information so that we can properly communicate with insurance companies and other medical providers. Social security numbers are a requirement when we carry the contract. Thank you.

Patient

First Name______________________________________

Last Name______________________________________

Social Security #__________________________________

Date of Birth____________________________________

Address____

City/State/Zip____________________________________

Home Phone_____________________________________

Cell Phone______________________________________

E-mail____

Occupation______________________________________

Employer_______________________________________

Work Phone_____________________________________

Would you like to receive e-mail reminders? ☐ Yes ☐ No

Would you like to receive text message reminders? ☐ Yes ☐ No

If yes; Cell Phone Carrier___________________________

PRIMARY DENTAL INSURANCE COMPANY

Insured Party____________________________________

Relationship_____________________________________

Employer_______________________________________

Bus. Address_____________________________________

Date of Birth____________________SS#_______________

Ins. Co. Name____________________________________

Address____

Group #_______________Group Name ___________________

Subscriber I.D. # __________________________________

Patient's Spouse

First Name______________________________________

Last Name______________________________________

Social Security #__________________________________

Date of Birth____________________________________

Address____

City/State/Zip____________________________________

Home Phone_____________________________________

Cell Phone______________________________________

E-mail____

Occupation______________________________________

Employer_______________________________________

Work Phone_____________________________________

Would you like to receive e-mail reminders? ☐ Yes ☐ No

Would you like to receive text message reminders? ☐ Yes ☐ No

If yes; Cell Phone Carrier___________________________

SECONDARY DENTAL INSURANCE COMPANY

Insured Party____________________________________

Relationship_____________________________________

Employer____

Bus. Address_____________________________________

Date of Birth____________________SS#_______________

Ins. Co. Name____________________________________

Address____

Group #_______________Group Name___________________

Subscriber I.D. # __________________________________

Primary concern with teeth:____

Has the patient been under the care of a physician during the past two years?

Physician's name City

Is the patient taking any medication or drugs?

Does the patient have a history of major illness or hospital stay?

Please check the following that the patient has been diagnosed with:

- ☐ Allergies (seasonal)
- ☐ Allergies (metal)
- ☐ Allergies (latex)
- ☐ Allergies (medication)
- ☐ Asthma
- ☐ Congenital Defects
- ☐ Behavorial/Learning problems
- ☐ Diabetes (Type:)
- ☐ Epilepsy
- ☐ Headaches (Frequency)
- ☐ Heart Murmur
- ☐ HIV/Aids
- ☐ Injury to face/jaw (Please explain below)
- ☐ Rheumatic Fever
- ☐ Psychiatric Illness (examples: depression, bipolar, anxiety)
- ☐ Tuberculosis

Describe other medical concerns:

Special needs:

Have tonsils and adenoids been removed? If yes, what age?

Has the patient ever sucked a thumb or fingers? If yes, until what age?

Has the patient or other family members had any previous orthodontic treatment?

Has the patient been informed of any missing or extra permanent teeth?

Does the patient have any jaw pain or noise in the jaw joint?

Have there been injuries to the face, mouth or teeth?

Women only: Is there a possibility of pregnancy? Expected delivery date

May we thank someone for referring you to our office?

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature Today's date