CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

A B C

Date_____ Patient Name_____ Birthdate_____

Legal Guardian/Responsible Party Name_____ Marital Status_____

Mailing address_____ City_____ State_____ Zip_____

How long at this address_____ Home Phone_____ Cell Phone_____

Previous address (if less than 3 yrs.)_____

E-Mail address_____ Work Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Yrs Employed_____

Other Legal Guardian_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Yrs Employed_____

Social Security #_____ Birthdate_____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Primary Insured Name_____ Relationship to Patient_____

Employer_____ Birthdate_____

Insurance Co_____ Phone Number_____

Subscriber ID or SS#_____ Policy #_____ Group #_____

- I agree to be responsible for all charges for dental services and materials not paid by my dental insurance benefit plan, unless prohibited by law, treating dentist or dental practice has contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Parent/Guardian Signature_____ Date_____

- I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to Henry D. Browning IV, DDS, PA and/or Browning Orthodontics.

Parent/Guardian Signature_____ Date_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Phone_____ Relationship_____

- I understand that when appropriate, credit bureau reports may be obtained.

Guardian/Responsible Party Signature_____

Henry D. Browning IV, D.D.S., P.A.
Orthodontics for Children & Adults

604 Junction Creek Drive • Wilmington, NC 28412 • (910) 793-2520

Date_____20____

Patient's Name_____Patient's birthdate_____ Age_____Gender_____

Patient's Primary Address_____ City_____State_____Zip Code_____

Patient Lives With ☐ Mother ☐ Father ☐ Both Parents ☐ Other _____ Telephone (____)_____

School _____ Grade_____ Referred by_____

Patient's Dentist_____ Physician _____

Patient's last professional dental cleaning and check-up_____ Siblings/Age_____

Medical History

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Bone Disorders	☐	☐	Asthma	☐	☐	Liver Involvement	☐	☐
Pneumonia	☐	☐	Tuberculosis	☐	☐	Kidney Involvement	☐	☐	Fainting & Dizziness	☐	☐
Heart Trouble	☐	☐	Anemia	☐	☐	Endocrine	☐	☐	Nervous Disorders	☐	☐
Rheumatic Fever	☐	☐	Epilepsy	☐	☐	Prolonged Bleeding	☐	☐	HIV (AIDS virus)	☐	☐

	Yes	No
Do you require premedication before dental appointments? _____	☐	☐
Are you in good health?_____	☐	☐
Are you under the care of a physician (if so, why?) _____	☐	☐
List any medications you are taking at this time: _____		
_____		
List any allergies or drug sensitivities:_____		
List any other medical conditions:_____		
Has patient reached puberty? Girls – have you started menstruation? _____	☐	☐
Boys – has your voice changed?_____	☐	☐

Signature _____Date_____
(parent or guardian if patient is a minor)

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆**For Office Use Only**◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

Date_____ M / D Panorex _____ Photos_____

Molars R_____ L_____ OB_____ OJ_____ Primary dentition:
Cuspids R_____ L_____
Midline Mx_____ Md_____ Crossbite

Upper crowding Lower crowding

Profile _____
Lip posture _____
Chin-throat depth_____
Labiomental fold_____
Abnormal frenum_____
Attitude towards treatment_____
Other:

Oral hygiene_____
Caries_____
Perio_____
Eruption concerns _____

Habits_____

TMJ R L
Click
Pain
Trauma
Max. opening_____
CR = CO_____

Recommendation: Obs / Phase I / Phase II / Other Spacers Bands

Extractions / Impactions / Surgery Upper Lower

Estimated Length of Treatment: Expander Retainers