SPROWLS ORTHODONTICS
Simply Outstanding Smiles

Springboro Location
888 W. Central Ave.
Springboro, OH US 45066
Phone: 937-746-3405

Confidential Patient Information

Legal First Name: _____

Legal Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Birthdate: _____ ☐Male ☐Female

Dentist: _____

Dentist's Address: _____

_____

Emergency Contact:

_____

Emergency Contact Phone: _____

Relationship to Patient: _____

How did you hear about our office?

☐ Dentist: _____ ☐ Patient: _____ ☐ Parent of Patient: _____

☐ Yelp ☐ Facebook ☐ Google ☐ Ad: _____ ☐ Other: _____

The American Association of Orthodontists recommends all children have a check-up with an orthodontist by age 7.
We will send you a reminder when a sibling is reaching age 7 to come in for a complimentary exam.

Sibling Name _____ Birthdate: _____ ☐Male ☐Female

Sibling Name _____ Birthdate: _____ ☐Male ☐Female

Responsible/Financial Party

(complete blue items below if you are an adult patient)

Relationship to Patient:

☐ mother ☐ father ☐ other _____

First Name: _____

Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Primary Phone: _____ ☐ home ☐ cell

Would you like to receive CALL reminders to this #? yes / no
Would you like to receive TEXT reminders to this #? yes / no
Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____

Email: _____

Would you like to receive EMAIL reminders? yes / no
Is it ok to send treatment & financial messages to this email? yes / no

☐ single ☐ married ☐ divorced

Other Responsible Party

(another person you authorize to access patient info)

Relationship to Patient:

☐ mother ☐ father ☐ other _____

First Name: _____

Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Primary Phone: _____ ☐ home ☐ cell

Would you like to receive CALL reminders to this #? yes / no
Would you like to receive TEXT reminders to this #? yes / no
Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____

Email: _____

Would you like to receive EMAIL reminders? yes / no
Is it ok to send treatment & financial messages to this email? yes / no

☐ single ☐ married ☐ divorced

(continued on reverse side)

Patient Health Information

Medical Doctor's Name: _____ Medical Doctor's Phone: _____

YES	NO		YES	NO	
☐	☐	Pregnant	☐	☐	Injuries to face, jaw, mouth or teeth
☐	☐	Latex allergy (reaction to balloons, rubberbands, etc.)	☐	☐	Any speech problems/therapy
☐	☐	Other allergy _____	☐	☐	Grind or clench teeth
☐	☐	Current medications _____	☐	☐	Pain, tenderness or noise in jaw
☐	☐	Heart condition _____	☐	☐	Discomfort from teeth or gums
☐	☐	Frequent headaches	☐	☐	Are there any other dental/medical problems of which our doctors should be aware
☐	☐	Hepatitis			_____
☐	☐	HIV/AIDS			_____

Dental Insurance Information

Do you have insurance that covers orthodontic treatment? ☐ YES (complete below) ☐ NOT SURE (complete below) ☐ NO

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Company's Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Employer's Name: _____

Subscriber's Social Security #: _____ Subscriber's Birthdate: _____

Our office will send a claim to your insurance company on your behalf. The signer of the financial agreement with Sprowls Orthodontics is responsible for the financial contract in its entirety. Any non-payment or claim denial from the insurance company is not the responsibility of Sprowls Orthodontics.

Signature: _____ **Date**: _____

_____ ***(Initial)*** Cancellation policy: I understand I must give at least 1 (one) business day's notice to change or cancel my appointment in order to avoid being charged a $25 fee.

_____ ***(Initial)*** The information provided is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for the payment of services rendered.

_____ ***(Initial)*** I authorize the release of dental/medical/insurance records to other dental/medical offices involved in the patient's continued orthodontic/dental treatment.

_____ ***(Initial)*** I acknowledge that I have received your NOTICE OF PRIVACY PRACTICES containing a complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its NOTICE OF PRIVACY PRACTICES, and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____