

Heartland Professional Building
2401 Ring Road
Elizabethtown, KY 42701
(270) 765-6502
Fax: (270) 766-1988

WELCOME

618 River Ridge Plaza
Brandenburg, KY 40108
(270) 422-KIDS
(270) 422-5437
Fax: (270) 422-5447

John J. DuPlessis, Jr. D.M.D., P.S.C.

Patient Information

Date _____ Home Phone _____
Name _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____ Weight _____ Height _____
Patient School or Employed by _____ Grade in School or Occupation _____
Favorite Activities _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____

INSURANCE CLAIMS ARE FILED ELECTRONICALLY. THE FOLLOWING INFORMATION MUST BE FILLED OUT COMPLETELY IN ORDER TO PROCESS YOUR CLAIM.

Responsible Party Primary Insurance

Subscriber/Responsible Party _____
Last Name First Name Initial
Relation to Patient _____ Social Security # _____ Birthdate _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed By _____ Employer Phone _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____

Additional Insurance

Is patient covered by additional insurance: Yes No
Subscriber Name _____ Relation to Patient _____ Birthdate _____ SSN _____
Address (if different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Employer Phone _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependants covered under this plan _____

Dental History

Reason for Today's Visit _____

Dentist _____

Address _____

Date of last dental care _____ Date of last Panoramic Dental X-rays _____

Does anyone else in the family have a similar orthodontic problem? _____

The Patient Resembles Mother and/or Father _____ Any Baby Teeth or Permanent Teeth Removed by your Dentist? _____

Any Major Falls or Accidents (particularly in the area of the face)? _____

Any Thumb/Finger Sucking Habits? _____ Other _____

Has the Individual been Examined by an Orthodontist before? _____ When _____

Where _____ What were the Findings _____

In your Own Words, what is the Problem? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List the medications you are currently taking:

ALLERGIES

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that a credit reporting agency may be contacted.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.