

FORT COLLINS 4144 Timberline Road (970) 226-6443

LOVELAND

3520 E. 15th Street • Suite 101 (970) 226-6443

WELCOME TO CRANE & SEAGER ORTHODONTICS

Making A Difference, One Smile At A Time

The benefits of a happy, healthy smile are immeasurable. Please fill out this form completely so we can best care for you.

ABOUT YOU	ORTHODONTIC INSURANCE
Today's Date:	PRIMARY ORTHODONTIC INSURANCE INFORMATION
Email Address:	Orthodontic Coverage: Yes No
May We Email You With Special Offers, Exclusive Events & Contests: Yes No	Insurance Co. Name:
Name:	Insurance Co. Address:
I prefer to be called: Male Female	Insurance Co. Phone #: ()
Birthdate:// Age: SS#:	Member ID # or Policy #:
Home Address:	Insured's Name: Relation:
	Insured's Birthdate: / / Insured's ID#:
Single Married Divorced Widowed Separated	Insured's Employer:
Hm #: () Cell/Other #: ()	SECONDARY ORTHODONTIC INSURANCE INFORMATION
Wk #: () Ext	Orthodontic Coverage: Yes No
Employer:	Insurance Co. Name:
Employer's Address:	Insurance Co. Address:
How long there?Occupation:	Insurance Co. Phone #: ()
Best time & place to reach you?	Member ID # or Policy #:
Whom may we thank for referring you?	Insured's Name: Relation:
Other family members seen by us?	Insured's Birthdate: / / Insured's ID#:
General dentist:	Insured's Employer:
Last visit date:	
Spouse Name:	In the event of an emergency, is there someone who lives near you that we should contact? Name: Relation: Wk #: () Hm #: ()
Cell #: (/ / / /	
	4 MEDICAL HISTORY
Person Financially Responsible for Account:	Do you have a general physician: Yes No
Wk #: () Ext Hm #: ()	Physician's Name:
Billing Address:	Wk #: () Date of Last Visit:
Relation: SS #:	
Employer: DL #:	CONTINUED ON BACK

M N Difficulty Breathing Y N Radiation Treatment Drug/Alcohol Abuse Y N Rheumatic/Scarlet Fever Y N Emphysema Y N Severe/Frequent Headaches Y N Epilepsy/Seizures/Fainting Y N Sindle Cell Disease/Traits Y N Glaucoma Y N Sinus Problems Y N Sinus Problems Y N Heart Attack/Stroke Y N Tuberculosis (TB) Y N Heart Attack/Stroke Y N Tuberculosis (TB) Y N Heart Surgery/Pacemaker Y N Venereal Disease Please list any serious medical condition(s) that you have ever had: Are you allergic to any of the following: Y N Dental Anesthetics Y N Aspirin Y N Penicillin Y N Other Are you allergic to any of the following: Y N Dental Anesthetics Y N Aspirin Y N Penicillin Y N Other Please list any other drugs/materials that you are allergic to: Thank You for filling out this form completely. If this office reserves the right to verify the credit status of potential payment of services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I hereby	4 MEDICAL HISTORY continued	5 DENTAL HISTORY
Name	our current physical health is: Good Fair Poor	
Averyou verified or been evaluated for property control or for Women: Have you ever had or been evaluated for property considerable with any previous dental work? Yes No ware you pregnant? Yes No ware you present work? Yes No ware you pregnant? Yes No ware you present work? Yes No ware you prevent work? Yes No ware you prevent was as official conditions? No Anormal Bleading Yn Hemophilia No Hemophilia Yn Anormal Bleading Yn Hemophilia No Hemophilia Yn Anormal Bleading Yn Hemophilia Yn Hemo	are you currently under the care of a physician?	orthodontics to accomplish?
Please list each one: For Women: For Women: For Women: For Women: For Women: For You grap a prescribed method of birth control? 'yes No orthodomic treatment? For you using a prescribed method of birth control? 'yes No ware you user had a serious/difficult problem associated with any prevolus dental work? yes No ware you user had any of the following diseases or medical conditions? In A Anormia Yn Hepatitis Yn Hepa	Please explain:	
The set les eich one: or Women: Are you using a prescribed method of birth control? Yes No Week #: Are you ground Yes No Are you using a prescribed method of birth control? Yes No Are you unusing? Yes No Have you ever had any of the following diseases or medical conditions? N. Anormal Bleeding Y. N. Hempphila N. Anormal Bleeding Y. N. Hempphila N. Anormal Bleeding Y. N. Hempphila N. Antificial Bones-Cyclints/Yalves Y. N. Hight-Low Blood Pressure N. Ashimal-Arthritis Y. N. HIV-A/DS N. Blood Transitusion N. Cancer/Chemchreapy Y. N. Kidney Problems N. Congenital Heart Defect Y. N. Mitral Vake Probages N. Difficially Breathing Y. N. Baldison Treatment N. Difficially Breathing Y. N. Sicko Coll Decase/Traits N. Emphysema Y. N. Sicko Coll Decase/Traits N. Feyro Biolipsy/Scizures-Fainting Y. N. Sicko Coll Decase/Traits N. Heart Attack/Stroke Y. N. Venereal Disease Please list any serious medical condition(s) that you have ever had: Are you allergio to any of the following: N. Dental Anosthotics Y. N. Aspirin Y. N. Penicillin N. Ocinem Y. N. Latex Y. N. Other Please list any other drugs/materials that you are allergic to: Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential batteries and/or parents of patients prior to actending credit for retainment fees and may, at the discretion of the office, use the services of one or more credit reporting services. Thank You for filling out this form completely. If this office accepts insurance, I understand that I am responsible to payment of the group insurance benefits (otherwise payabl to me) directly to this office. Signature Date Optice is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the COC and the . OFFICE USE ONLY - O	re you taking any prescription/over-the-counter drugs? 🗌 Yes 🗌 No	
For Women: Yer you using a prescribed method of birth control?	Please list each one:	
Are you using a prescribed method of bith control? Yes No week #:	for Women:	
Are you new rad any of the following diseases or medical conditions? N. Anormal Bleading Y. N. Hemophilia Y. N. Hemophilia Y. N. Hemophilia Y. N. Any Hemophilia Y. N. Any Hemophilia Y. N. Hemophilia Y. N. Any Hemophilia Y. N. Hemophilia Y. N. Any High Low Blood Pressure Y. N. Ashma/Arthritis Y. N. High Low Blood Pressure Y. N. Biood Transfusion Y. N. High Low Blood Pressure Y. N. Biood Transfusion Y. N. High Low Blood Pressure Y. N. Biood Transfusion Y. N. Hophilia Y. N. Ashma/Arthritis Y. N. High Low Blood Pressure Y. N. Difficulty Breathing Y. N. Hophilia Y. N. Pachtain Problems Y. N. Disabetes Y. N. Psychiatric Problems Y. N. Disabetes Y. N. Psychiatric Problems Y. N. Disabetes Y. N. Psychiatric Problems Y. N. Epiloppy-Sectures/Fainting Y. N. Sinke Cell Disease/Traits Y. N. Glaucoma Y. N. Sinke Problems Y. N. Heart Attack/Stroke Y. N. Sinker Problems Y. N. Heart Attack/Stroke Y. N. V. Diere-Zollts Y. N. Heart Attack/Stroke Y. N. V. Diere-Zollts Y. N. Heart Attack/Stroke Y. N. V. Diere-Zollts Y. N. Any Metal-Please list any serious medical condition(s) that you have ever had: **N. Pearl Attack/Stroke Y. N. Aspirin Y. N. Penicillin Y. N. Any Metal-Pleases I Y. N. Aspirin Y. N. Penicillin Y. N. Any Metal-Pleases I Y. N. Aspirin Y. N. Penicillin Y. N. Any Metal-Pleases Y. N. Aspirin Y. N. Tetacoptine Y.	re you using a prescribed method of birth control? Yes No	
Here you urising? Yes No Have you ever had any of the following diseases or medical conditions? / N Abnormal Bleeding	re you pregnant? Yes No Week #:	Do you have as have you ever experienced
Have you ever had any of the following diseases or medical conditions? / N Abnormal Bleeding	re you nursing? Yes No	
N Abnormal Bleeding		
N Anemia		
Martificial Bones/Joints/Valves Y N Hight/Low Blood Pressure	-	
N Ashma/Arthritis Y N HIV+/AIDS N Blood Translusion Y N Hospitalized for Any Reason N Cancer/Chemotherapy N Congential Heart Defect Y N Mitral Valve Problems N Do you have any speech problems? N Didriculty Breathing Y N Radiation Treatment N Drug/Alcohol Abuse Y N Rychilatric Problems N Didriculty Breathing Y N Radiation Treatment N Drug/Alcohol Abuse Y N Sychilatric Problems N Spilepsy/Seizures/Fainting Y N Shingles N Spilepsy/Seizures/Fainting Y N Shingles N Glaucoma Y N Sickle Coll Disease/Traits N Glaucoma Y N Sickle Coll Disease/Traits N Heart Attack/Stroke Y N Tuberculosis (TB) N Heart Attack/Stroke Y N Venereal Disease Please list any serious medical condition(s) that you have ever had: Correct to the best of my knowledge. I also understand that the information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medics status. Lauthorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Thank You for filling out this form completely. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any	·	
N Blood Transfusion	9	
N Cancer/Chemotherapy Y N Kidney Problems N Congenital Heart Defect Y N Mitral Valve Prolapse N Congenital Heart Defect Y N Mitral Valve Prolapse N Diblects Y N Psychiatric Problems N Drug/Alcohol Abuse Y N Radiation Treatment N Drug/Alcohol Abuse Y N Recythatric Problems N Drug/Alcohol Abuse Y N Stoke Problems N Emphysema Y N Severe/Frequent Headaches N Epilepsy/Scizures/Fainting Y N Shingles N Epilepsy/Scizures/Fainting Y N Shingles N Sinus Problems N Heart Attack/Stroke Y N Tuberculoisis (TB) N Heart Attack/Stroke Y N Venereal Disease Please list any serious medical condition(s) that you have ever had: Are you allergic to any of the following: N Dential Anesthetics Y N Aspirin Y N Penicillin N Dential Anesthetics Y N Aspirin Y N Penicillin N Dential Anesthetics Y N Aspirin Y N Penicillin N Codeine Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for reatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for reatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. This office reserves the right to werify the credit status of potential patients and/or parents of patients prior to extending credit for reatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. This office reserves the right to werify the credit status of potential patients and/or parents of patients prior to extending credit for reatment fees and may, at the discretion of the office, use the services of the file of the office of		Do you have any speech problems?
If Yes, please circle: While Awake? While Asleep? N Dilabetes Y N Psychiatric Problems N Dilficulty Breathing Y N Radiation Treatment N Dilficulty Breathing Y N Radiation Treatment N Dilficulty Breathing Y N Radiation Treatment N Epilepsy/Seizures/Fainting Y N Shingles N Fewer Blisters Y N Shingles N Heart Attack/Stroke Y N Tuberculosis (TB) N Heart Aurmur Y N Subus Problems N Heart Attack/Stroke Y N Tuberculosis (TB) N Heart Aurmur Y N Suberself Beases Please list any serious medical condition(s) that you have ever had: Are you allergic to any of the following: N Dental Anesthetics Y N Aspirin Y N Penicilling N Codeine Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential patents and/or parents of patients prior to extending credit for reatment lees and may, at the discretion of the office, use the services of one or more credit reporting services. Place Services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment of services rendered and also responsible for paying any copayment of the group insurance benefits (otherwise payable to me) directly to this office. OFFICE USE ONLY -	· · · · · · · · · · · · · · · · · · ·	Do you generally breathe through your mouth? Yes No
N Difficulty Breathing		If Yes, please circle: While Awake? While Asleep?
No Difficulty Breathing	N Diabetes Y N Psychiatric Problems	Do you have any missing or extra permanent teeth? Yes N
Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential and/or parents of patients prior to extending credit for paying any core more credit reporting services. Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for paying any core more credit reporting services. To Filce USE ONLY - OFFICE USE ONLY	, , , , , , , , , , , , , , , , , , , ,	Have you ever taken Fosamax.
N Epilepsy/Seizures/Fainting Y N Shingles Shingles Y N Shingles Shingles Y N Shingles	-	
N Fever Blisters	· · ·	Have you ever taken Phen-Fen?
N Glaucoma Y N Sinus Problems N Heart Murmur Y N Ulcers/Collis N Heart Surgery/Pacemaker Y N Venereal Disease Please list any serious medical condition(s) that you have ever had: Are you allergic to any of the following: Are you allergic to any of the following: N Dental Anesthetics Y N Aspirin N Any Metals/Plastics Y N Erythromycin N Codeine Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential abiliants and/or parents of patients prior to extending credit for reatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the office USE ONLY - OFFIC		Do you smoke or use tobacco in any form?
N Heart Attack/Stroke		
Please list any serious medical condition(s) that you have ever had: Are you allergic to any of the following: Are you allergic to any of the following: N Dental Anesthetics Y N Aspirin Y N Penicillin Y N Any Metals/Plastics Y N Erythromycin Y N Tetracycline Y N Codeine Y N Latex Y N Other Please list any other drugs/materials that you are allergic to: Thank You for filling out this form completely. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for reatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. The please list and compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the office USE ONLY - O		
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verbally reviewed the medical/dental information above with the patient named herein. Initials: Date:	STITUTE OF THE OF THE OFFICE OF	SOLUTION STREET SOLUTION STREET SOLUTION