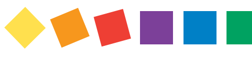

RxSmile GREG GREENBERG D.D.S.
ORTHODONTICS EXCLUSIVELY

Building Beautiful Smiles...Together!

www.rxsmile.com ▪ Member American Association of Orthodontists

Dallas
8510 Abrams Rd. at Royal Ln.
Suite 508 ▪ Dallas, Texas 75243
P 214 503-0060 ▪ F 214 503-0023

Frisco
6801 Warren Parkway
Suite 121 ▪ Frisco, Texas 75034
P 972 335-1300 ▪ F 972 335-1313

Patient Number ____________

DATE ____________

PATIENT INFORMATION

Name ____________ Nickname ____________ Birthday ________ Age ____ Sex ____

Address ____________ City ____________ State ______ Zip ________

Phone ____________ Cell Phone ____________

School ____________ Dentist ____________ Physician ____________

Hobbies ____________ Email ____________

Who may we thank for referring you to our office? ____________

Siblings ____________ Age ____________

BILLING PARTY INFORMATION

This Section Must Be Completely Filled Out!

SELF or FATHER INFORMATION

Name ____________

Address ____________

City ____________ State ____ Zip ____________

Home Phone ____________

Cell Phone ____________

Work Phone ____________

Email ____________

Birthday ________ Age ____ Sex ____ Marital Status ________

SSN ____________

Relationship to patient ____________

Occupation ____________

Employer ____________ Years employed ______

Employer Address ____________

____

INSURANCE INFORMATION

Orthodontic Coverage? ______ Yes ______ No

Insurance Company ____________

Address ____________

City ____________ State ____ Zip ____________

Phone ____________ extension ________

Group # ____________

ID# ____________

MOTHER or SPOUSE INFORMATION

Name ____________

Address ____________

City ____________ State ____ Zip ____________

Home Phone ____________

Cell Phone ____________

Work Phone ____________

Email ____________

Birthday ________ Age ____ Sex ____ Marital Status ________

SSN ____________

Relationship to patient ____________

Occupation ____________

Employer ____________ Years employed ______

Employer Address ____________

____

INSURANCE INFORMATION

Orthodontic Coverage? ______ Yes ______ No

Insurance Company ____________

Address ____________

City ____________ State ____ Zip ____________

Phone ____________ extension ________

Group # ____________

ID# ____________

Signature (Parent or Guardian signature if minor) ____________ Date ____________

I hereby authorize the release of any treatment information, assign insurance benefits directly to the above named dentist, otherwise payable to me and give Greg Greenberg, D.D.S., permission to obtain my credit history for the sole purpose of financing orthodontic treatment provided by this office.

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____
Patient Number

____
DATE

PATIENT'S MEDICAL HISTORY

Patient's Name: ______________________________ Date of Birth: ____________

Have you been under the care of a physician in the last two years: ______________________________

Have you ever had or do you now have any of the following:

____ Fainting or Dizziness
____ Rheumatic Fever
____ Prolonged Bleeding
____ ADHD
____ Anemia
____ Diabetes
____ Epilepsy
____ Arthritis
____ Bone Disorders
____ Nervous Disorder
____ Adenoids removed
____ Allergies (Seasonal)
____ Artificial heart valves
____ Bruxing
____ Cardiac pacemaker
____ Congenital heart lesions
____ Chronic cough
____ Diabetes
____ Ear problems
____ Osteoporosis
____ Scoliosis
____ Sinus trouble
____ Swelling of ankles
____ Thyroid problems
____ Venereal disease

____ Endocrine Problems
____ Asthma
____ Tuberculosis
____ AIDS or HIV
____ Hepatitis, Type______
____ Liver Problems
____ Cancer
____ Birth Defects
Allergies (To Medications or Materials)
____
____
____ Emotional problems
Headaches (frequent)
____ High or low blood pressure
____ Jaundice
____ Joint swelling
____ Kidney treatment
____ Organ transplant
____ Psychiatric treatment
____ Shortness of breath
____ Stroke
____ TMJ
____ Tonsils removed
____ Whiplash

Have you been hospitalized?
Yes No
Have you had any operations?
Yes No

List any medications you are taking.
____
____
____

Any injuries to face, mouth, teeth?
Yes No
Thumb, finger, lip sucking?
Yes No
Mouth-breathing when asleep, awake?
Yes No
Any missing permanent teeth?
Yes No
Any extra permanent teeth?
Yes No
Is there a tongue-thrust problem?
Yes No
Any speech problems?
Yes No
Any pain or clicking on opening mouth?
Yes No

List any other serious illnesses ______________________________
Has an orthodontist been consulted previously?_______ Reason ______________________________
What would you like to have orthodontic treatment accomplish? ______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________________
Address ______________________________ Phone ______________
Signature (Parent of minor patient) ______________________________ Date ______________
Reviewed by Dr. ______________________________ Date ______________