

Bancroft Orthodontics

JAMES J. BANCROFT, DMD
SPECIALTY PERMIT #3319
ASHLEY BANCROFT-DOBRIN, DMD, MBA
SPECIALTY PERMIT #06510
KEITH R. DOBRIN, DMD, MBA
SPECIALTY PERMIT #06556

Date _____

Patient Information

Patient Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

Address _____

City, State, Zip _____

Home Phone: _____

Cell #: _____

E-mail: _____

Confirmation Preference: Text E-mail Phone Call

Current Dentist _____

Dentist Phone # _____

Physician _____

Referred by _____

Cell provider(Verizon/Sprint/etc): _____

Employer _____

Occupation _____

Work Number _____ Ext _____

Marital Status (circle one): Single / Married / Divorced / Widowed / Separated

Spouse

Name _____

Phone # _____

Employer _____

Occupation _____

Work # _____ Ext _____

Orthodontic Insurance

Insurance Company _____

Insurance Co. phone # _____

Insurance Co. Address _____

Suscriber's Name _____


Relationship _____

Birthdate _____ Soc. Sec. # _____

Group # _____

ID # _____

For office use only

Please continue to next page 

Molar Class: CI I End-on CI II Full-step CI II Super CI I CI III N/A

Canine Class: CI I End-on CI II Full-step CI II Super CI I CI III N/A

Condition: Crowding Spacing Impactions

Overbite: _____ Overjet: _____

Treatment: Comprehensive Tx Limited Tx

Modality: Twin Damon Ceramic Invisalign

CONFIDENTIAL
Dental & Health History

Your overall health as well as any medications, which you may take, could have an important interrelationship with the dental care you receive. Please answer the following questions completely.

How often do you brush? _____ How often do you floss? _____

Is your water fluoridated? Yes No
Does you take fluoride supplements? Yes No
Do you:
Suck thumb/finger Yes No
Suck/Bite lip Yes No
Bite/Chew nails Yes No
Chew hard objects Yes No
Grind teeth Yes No
Clench jaws Yes No

Have you had difficulty with previous dental visits? _____
Do you have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? _____
Do you have a latex allergy or any other allergy?

Are you currently taking any medications? Yes No (If yes, please list)

Have you ever had any of the following: (if yes please explain below)*

Abnormal Bleeding	Yes No	Asthma	Yes No
Cancer	Yes No	Congenital heart Defect	Yes No
Convulsions/Epilepsy	Yes No	Diabetes	Yes No
Handicaps/Disabilities	Yes No	Heart Murmur	Yes No
Hemophilia	Yes No	Hepatitis	Yes No
HIV/AIDS	Yes No	Hypertension	Yes No
Rheumatic Fever	Yes No	Stomach/liver/kidney problems	Yes No
Tuberculosis	Yes No		

*Please explain any medical problems that you have: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I also authorize this dental staff to perform the necessary dental services I may need. I also authorize Dr. Bancroft to release any information including the diagnosis and the records of treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Bancroft otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or dependents.

Signature of patient

Date