shineorthodontics
Dr. Michael K. Agenter, DDS, MDS

New Patient Form

Patient Information

_____ First _____ MI _____ Last ____/____/____ Date of Birth

_____ Address ☐ M ☐ F Sex

_____ City _____ State _____ Zip

(_____) _____-_____ Home (_____) _____-_____ Cell (_____) _____-_____ Other

_____ Family Dentist (_____) _____-_____ Phone

_____ If patient is a minor, who is with them today? _____ Relationship

☐ Y / ☐ N If applicable, do you have custody?

If any other family members are patients at this office, please list them here.

_____

_____

_____

_____

Responsible Party Information

_____ First _____ MI _____ Last _____ Relationship

_____ Address (_____) _____-_____ Home

_____ City _____ State _____ Zip (_____) _____-_____ Cell

_____ Email Address (_____) _____-_____ Other

Health History

☐ Yes ☐ No *Is the patient currently under the care of a physician?*
☐ Yes ☐ No *Is the patient currently on drugs or medication?*
☐ Yes ☐ No *Does the patient have any allergies or drug sensitivities?*
☐ Yes ☐ No *Has the patient ever been informed of missing or extra permanent teeth?*
☐ Yes ☐ No *Has the patient had any injuries to the face, mouth, or teeth?*
☐ Yes ☐ No *Is the patient a mouth breather?*
☐ Yes ☐ No *Has the patient ever sucked thumb or fingers?*
☐ Yes ☐ No *Are there any other medical conditions that we should be aware of?*

If yes to any, please explain: _____

_____

Please select any ways that you have heard about Shine Orthodontics

☐ Facebook
☐ Website
☐ Insurance
☐ School Folder
☐ Invisalign
☐ Drive by/signage
☐ Ice Cream Truck
☐ School Sponorship
☐ Sports Banner
☐ Friend/Family _____
☐ Billboard _____
☐ Dentist _____
☐ Staff _____
☐ Other _____

Primary Insurance Information

_____ (____) ____-_____
Insurance Company *Phone*

_____
Insurance Company Address

_____ ____ _____
City *State* *Zip*

_____ ____ _____
Subscriber's First Name *MI* *Subscriber's Last Name*

_____ ____/____/____
Subscriber ID or SSN *Date of Birth*

_____ (____) ____-_____
Subscriber Employer *Employer Phone*

☐ Employee ☐ Spouse ☐ Dependent
Coverage for (select all)

Ortho Coverage?
☐ Y / ☐ N

Benefits Paid At

_____%

Life Max

$_____

Amount Used

$_____

Amount Available

$_____

Secondary Insurance Information

_____ (____) ____-_____
Insurance Company *Phone*

_____
Insurance Company Address

_____ ____ _____
City *State* *Zip*

_____ ____ _____
Subscriber's First Name *MI* *Subscriber's Last Name*

_____ ____/____/____
Subscriber ID or SSN *Date of Birth*

_____ (____) ____-_____
Subscriber Employer *Employer Phone*

☐ Employee ☐ Spouse ☐ Dependent
Coverage for (select all)

Ortho Coverage?
☐ Y / ☐ N

Benefits Paid At

_____%

Life Max

$_____

Amount Used

$_____

Amount Available

$_____

Please choose YES or NO for each of the following:

☐ Yes ☐ No ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ Yes ☐ No I authorize Agenter Orthodontics to use my personal images (photos & x-rays) and testimonials for purposes such as learning procedures, website, Facebook, office TV and /or commercials. I give consent with no claim for payment.

☐ Yes ☐ No I give permission for Agenter Orthodontics to release medical/dental/financial information for the purpose of diagnostics, consulting and to collect insurance benefits on my part.

By signing below, you are acknowledging that you have read and understand the proceeding questions. You acknowledge the information is correct to the best of your knowledge and if there are any changes to history records or medical/dental status you will inform Agenter Orthodontics.

_____ _____/_____/_____
Patient / Parent / Guardian Signature *Date*