Nolan E Cordon DMD, MS, PC

Board Certified Orthodontic Specialist

Patient Name: _____ Phone: (____) _____ DOB: _____ M/F _____

Mailing Address: _____ City: _____ Zip: _____

Responsible Party for Account: _____
Address: _____
Relation to patient: _____
City: _____ Zip: _____
Home #: _____ Work #: _____
Cell #: _____ Date of Birth: _____
SSN: _____ Marital Status: _____
Responsible Party (other parent): _____
Relation to patient: _____
Address: _____
City: _____ Zip: _____
Home #: _____ Work #: _____
Cell #: _____ Date of Birth: _____
SSN: _____ Marital Status: _____
Emergency Contact: _____
Relationship: _____ Phone: _____
Address: _____

Primary Dental Insurance: _____
Policy Holder: _____
Policy Holder DOB: _____
SSN: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____
Group/Policy #: _____
Employer: _____

Secondary Dental Insurance: _____
Policy Holder: _____
Policy Holder DOB: _____
Ins. Co. Address: _____
Ins. Co. Phone: _____
SSN: _____
Group/Policy #: _____
Employer: _____

Dentist's Name: _____ Phone: _____
Have you ever had an injury to your face or jaw? _____ Date of last dental cleaning: _____
Reason for visit today? _____
How did you hear about our office? _____

Please circle if the patient ever had or has:

Allergies	Heart problems/Artificial valve/Pacemaker	Hepatitis/ Jaundice	Diabetes
Rheumatic fever	Mitral vavle prolapse/ Heart murmur	AIDS/HIV positive	Arthritis
Stomach problems	High blood pressure/ Blood disorder	Venereal Disease	Tuberculosis
Glaucoma	Epilepsy/ Seizures/ Nervous disorders	Joint replacement/Bone pins/plates	
Penicillin Allergy	X-ray treatment/ Chemotherapy/ Cancer	Medication allergies	

Have you ever been pre-medicated with antibiotics prior to a dental appointment? _____
Have you been under the care of a physician during the last two years? _____
Please list any medications the patient is currently taking: _____
Do you have any condition not listed above? _____
Women: Are you pregnant? _____ Taking birth control medication? _____
Explain any major illnesses: _____

I authorize Nolan E Cordon DMD, MS, PC to furnish information to insurance carriers concerning my dental/ orthodontic treatments and authorize to Nolan E Cordon DMD, MS, PC all payments for dental/ orthodontic services rendered for myself or my dependents. I understand that I am responsible for any amount not covered by insurance. If I agree to treatment, I give authorization for orthodontic treatment, including necessary x-rays, photos, and other acceptable methods to accomplish these services. I authorize the use of x-rays, photos, and other records for educational purposes. I authorize my (patient's) physician(s) and dentist(s) to release information necessary for treatment. I authorize Nolan E Cordon DMD, MS, PC to release information necessary for treatment to my (patient's) physician(s) and dentist(s). If I am not the policy holder of the insurance, I certify that I have the consent of the policy holder to bill their insurance. I am responsible to update Dr. Cordon of any changes in medical history/conditions or any medications being taken.

Signature of Parent/Legal Guardian/ Patient if over 18: _____ Date: _____

For Office Use Only

Patient Name: _____

Ins. Co. _____
Date: _____ Name: _____
Max: _____ %: _____
Used: _____ Waiting: _____
Provider: _____ Billing: auto/month
Address: _____
_____

Ins. Co. _____
Date: _____ Name: _____
Max: _____ %: _____
Used: _____ Waiting: _____
Provider: _____ Billing: auto/month
Address: _____
_____

For office use only

CC:

Exam:

Screen:

Notes: