Donihue Waters, DDS, MDS, PC
PRACTICE LIMITED TO ORTHODONTICS
9100 White Bluff Road, Suite 104
Savannah, GA 31406
(912)354-3474

Adult Patient Date: ___________________________

Patient's Name:____
(First) (Middle) (Last) (Nickname)

Date of Birth ______________________________________ Age: _____________________ Circle One: Male / Female

S.S. #: ____

Patient's Address:____

____ _________________________ ___________________________
(City) (State) (Zip Code)

Employer: _______________________________________

Employer Phone #: ________________________________

Our office uses an automated system for confirming all appointments. This system gives you the option for calling, email and text messages. What is the best telephone # and Email to use?

Telephone #: _____________________________________ ____
Circle One: Cell / Home (Email)

How did you hear about our office? ____

Are there other family members seen in our office? ____

Spouse: ____ Date of Birth: ______________________________

S.S. #: ____ Cell #: _____________________________________

Employer: _______________________________________ Work#: ____________________________________

Email: ____

MEDICAL HISTORY

Dentist: ____ Last Cleaning Date: __________________________________

Physician: ______________________________________

PLEASE CIRCLE THE FOLLOWING AS THEY APPLLY:

Asthma	*Jaw Locking*	*Mitro-Valve Prolapse*	*Facial Tooth Injury*
Epilepsy	*Liver Disease*	*Prophylactic Antibiotics*	*Blood Pressure*
Pregnancy	*Heart Disease*	*Jaw/Joint Noise*	*Previous TMJ Therapy*
Arthritis	*Missing Teeth*	*Chewing Problems*	*Contact Lenses*
Hepatitis	*Thumb Habits*	*Grinding of Teeth*	*Emotional Problems*
HIV/AIDS	*Rheumatic Fever*	*Previous Orthodontics*	*Gum Disease*
Frequent Headaches	*Diabetic*	*Periodic MRI/CT Scans*	*Osteoperosis(Fosamax/Evista)*
Diagnosed Syndromes	*Allergies (latex/metals)*	*Drug Allergies*	

Please explain in detail any health issues and list all medications currently taken (including non-prescription drugs):

____

*By signing below, I acknowledge the receipt of a copy of the Notice of Privacy Practices of Innovative Orthodontics, Donihue Waters, DDS, MDS.

____ Date: ______________________________
(Signature)

INSURANCE INFORMATION

PRIMARY:

Policy Holder: ______________________________ Telephone#: ______________________________

Date of Birth: ______________________________ S.S.#: ______________________________

DENTAL Insurance Carrier: ______________________________

Insurance Telephone #: ______________________________

DENTAL Claim Address:______________________________

______________________________ ______________ ______________
(City) (State) (Zip Code)

Member ID#:______________________________ Group#: ______________________________

Employer: ______________________________ Employer Phone #:______________________________

SECONDARY:

Policy Holder: ______________________________ Telephone#: ______________________________

Date of Birth: ______________________________ S.S.#: ______________________________

DENTAL Insurance Carrier: ______________________________

Insurance Telephone #: ______________________________

DENTAL Claim Address:______________________________

______________________________ ______________ ______________
(City) (State) (Zip Code)

Member ID#:______________________________ Group#: ______________________________

Employer: ______________________________ Employer Phone #:______________________________

Insurance: Our office files insurance as a courtesy for our patients. We cannot file your insurance without a copy of your insurance card. If you do not have a copy of your card, please contact your Human Resources Department for the following information: Policy holder's name as written on the card, name & address of the insurance company, phone number of the insurance company, Member ID# & the Group ID #.