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

Tell Us About Your Child: Date: _____

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

Date of Birth _____ Age: _____ Circle One: Male / Female

Patient's Address:_____

_____ _____ _____
(City) (State) (Zip Code)

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 that have ever seen in our office? _____

MEDICAL HISTORY

Dentist: _____ Last Cleaning Date: _____

Physician: _____

PLEASE CIRCLE THE FOLLOWING AS THEY APPLY:

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*	*Osteoporosis(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: _____
(Guardian's Signature)

INNOVATIVE | ORTHODONTICS

***Please list below all parties you wish to place on your child's account. Please understand anyone listed below are being granted full disclosure to financial and treatment information on file as designated below. If there are any specific privacy restrictions please inform our office!!!**

Mother: _____ Date of Birth: _____

S.S. #: _____ Cell #: _____

Employer: _____ Work#: _____

Address: (if different than child's): Home#: _____

_____ Email: _____

_____

Father: _____ Date of Birth: _____

S.S. #: _____ Cell #: _____

Employer: _____ Work#: _____

Address: (if different than child's): Home#: _____

_____ Email: _____

_____

(Please fill out the following if needed for billing and/or insurance)

Step-Mother: _____ Date of Birth: _____

S.S. #: _____ Cell #: _____

Employer: _____ Work#: _____

Address: (if different than child's): Home#: _____

_____ Email: _____

_____

Step-Father: _____ Date of Birth: _____

S.S. #: _____ Cell #: _____

Employer: _____ Work#: _____

Address: (if different than child's): Home#: _____

_____ Email: _____

_____

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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 #.