Drs. Cassinelli and Shanker - 2019

Date ____________________

Patient Information:

Last Name____________________ First_____________________ Middle_______________

Birth Date__________ Home Phone ____________ Cell Phone _______________ Cell Carrier_________

Email ______________________________ Interests ____________________________________

Home Address/City/State/Zip____

School ____ Grade______________

Name of Patient's Dentist ______________________ Name of Physician _______________

Responsible Parties:

Father or Guardian Name_____________________________ Marital Status: Married Single Divorced Separated

Home Phone _____________ Cell Phone ______________ Cell Carrier___________

Email ____________________________ Employer Name__________________________

Home Address/City/State/Zip____

Mother or Guardian Name_____________________________ Marital Status: Married Single Divorced Separated

Home Phone _____________ Cell Phone ______________ Cell Carrier____________

Email _____________________________ Employer Name__________________________

Home Address/City/State/Zip ____

Has your dental / orthodontic insurance coverage changed since last update? Yes No DK/U
If Yes please complete a new Dental Insurance Form. This form is available on our website or at the front desk.

Allergies or drug reactions? ____

Are you taking medication, nutrient supplements or non-prescription medicine?
Please list them: ____

Do you or have you taken a Bisphosphonate* drug? ____

Medical conditions/symptoms or significant changes that we should be aware of? _____________________

Being treated by another health care professional? ____

Indicate changes in pubertal status **(voice change-boys, menstruation- girls)**- please date & initial onset:____

*Actonel, Boniva, Fosamax, Fosamax Plus D, Skelid, Didronel, Aredia, Zometa, or Bonefos

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes in my child's/or my own medical condition, history or dental status I will so inform this practice.

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Signature of patient, parent or guardian Date