## Robert Perlot, D.M.D., M.S.

(360) 786-1600

Practice Limited to Orthodontics

Patient's Name	Middle	Last		Sex	_ Today's	s Date
Address	MINOR	Last	City		State	Zip
Home Phone			-			
Check Appropriate Box:   Mino Patient's Social Security #						□Widowed
Has anyone in your family been a	patient in our of	fice? □yes	□no Name(s	):		
Whom may we thank for referring	you to our offic	e?				
Family Dentist		Famil	y Physician			
	— Resnonsi	hle Party I	nformation			
Name	fiddle	Last		Relations	ship to Pa	atient
Address			City		_ State_	Zip
Social Security #	Birth	date/_	_/ Home	Phone:_		
Employer:			Cell/Work	Phone:		
Employers Address:			City		State_	Zip
Insurance Company:			Group No		ID	No
Insurance Co. Phone:				Uni	on/Local	No
Insurance Co. Address						
Does your plan have orthodonti	c coverage?	lyes □no	Lifetime Bene	efit Amou	int	
Name	Midelle.	Lost		Relations	ship to Pa	atient
Address						
Social Security #	Birth	idate/_	_/ Home	Phone:		
Employer:						
Employers Address:			City		State_	Zip
Insurance Company:			(	Group No	o	
Insurance Co. Phone:						
Insurance Co. Address						
Does your plan have orthodontic	coverage? Dyes	□no Lifetir	me Benefit Am	ount		
	Emer	gency Info	rmation —			
Name of nearest relative not living						
Signature (Parent's signature if mi						

PLEASE TURN OVER

Have you had a previous orthodontic con	sultation?			
Does the patient have any of the following	habits? Thumb sucking Mouth brea	thing Teeth grinding Other		
Please describe other:				
Section IV (all patients) MEDICAL HISTO				
Has the patient been under a physician's		r illness?		
Is the patient taking any medication?				
Is the patient allergic to any drug?				
Does the patient have a history of any of		T.M.J problems □ Yes □ No		
Asthma □ Yes □ No	Heart disease □ Yes □ No	Speech problems □ Yes □ No		
Convulsions □ Yes □ No	Permanent tooth loss .☐ Yes ☐ No	Epilepsy □ Yes □ No		
Allergies □ Yes □ No	Nasal obstructions ☐ Yes ☐ No	Bleeding disorders□ Yes □ No		
Rheumatic fever □ Yes □ No	Operations Yes No	Test positive to HIV □ Yes □ No		
Scarlet fever Yes No	Herpes □ Yes □ No	lest positive to HIV Li res Li No		
Heart murmur □ Yes □ No	Diabetes □ Yes □ No Tuberculosis □ Yes □ No	Female: Menstrual Cycle□ Yes □ No		
Hepatitis □ Yes □ No	Tuberculosis tes 🗆 No	Wenstidal Cycled res a re-		
Please list any significant medical or den	tal problems:			
	ase Do Not Write Below This Lin			
Name	Age Sex	Number		
TVAITIC				
Fee for TX: Est				
Fee for TX: Est				
Fee for TX: Est Financial: Adjustments				
Fee for TX: Est Financial: Adjustments Insurance				
Fee for TX: Est Financial: Adjustments Insurance Down				
Fee for TX: Est  Financial: Adjustments Insurance Down Monthly				
Fee for TX: Est Financial: Adjustments Insurance Down				
Fee for TX: Est  Financial: Adjustments Insurance Down Monthly				
Fee for TX: Est  Financial: Adjustments Insurance Down Monthly Payment		Phase of TX: Limited Misc I II F		
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## Orthodontic Insurance

As a courtesy towards your orthodontic care, our office will bill your insurance provider. We recommend that you contact your insurance prior to your appointment to confirm that there is orthodontic coverage for the patient.

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1. 2. 3.	Is there	coverage	ime orthodontic benefit amount? e for spouses and/or dependents? imit for orthodontic coverage?	
	high call your initi		s and automated systems we may be unable to contact your insurance	e company
			determine orthodontic benefits, we will need accurate information to lease have the following information available for your orthodontic co	
1.	Dental website		te card (if you do not have a dental card, they are available for print o	n the insurance
2.	*Subsc		ormation	
		Name_	f Birth	
		Date of	f Birth	
	•		iber ID# or SSN	
		Group I	Number	
		Name o	of Insurance Company	
	•		nce Company Phone	
		0	Secondary Insurance (if applicable)	
		0	Name	
		0	Date of Birth	
		0	Subscriber ID# or SSN	
		0	Group Number	
		0	Name of Insurance Company	
		0	Insurance Company Phone	

If you have any questions, please do not hesitate to contact our office at (360) 786-1600. We look forward to your visit!

Thank you,

The Team at Perlot Orthodontics

<sup>\*</sup>Please note that the subscriber may or may NOT be the patient!