Lorin A. Kaplan DDS, MSD
Orthodontic Specialist

Member American Association of Orthodontists

Adult Patient Update & Verification Form

Patient's Full Name_____ Nickname_____
First Middle Last

Address_____
Street City State Zip

Home#_____ Work#_____ Mobile #_____

Birthdate_____ Age_____ ❑ Male ❑ Female E-mail_____

Preferred contact for appt. reminders: ❑ Home phone ❑ Work phone ❑ Mobile ❑ E-mail ❑ Text

Marital Status: ❑ Married ❑ Divorced ❑ Domestic Partner ❑ Single

Spouse_____ Mobile #_____ E-mail_____
Name

Hobbies / Sports / Talents:_____

Responsible Party Information

Responsible Billing Party ❑ Self ❑ Spouse ❑ Other_____

❑ Yes ❑ No **Insurance coverage changed?** If yes: **New Insurance Company:**_____

_____
Address phone # Employer

Employee_____ SS#/ID#_____ Birthdate_____

Emergency Information

Emergency Contact_____
Neighbor or Relative not living with you. Relationship Phone #

Medical Update

❑ Yes ❑ No Since your last appointment have there been any changes in your health?
❑ Yes ❑ No Any serious illness or hospitalization?
❑ Yes ❑ No Are you under the care of a physician for any medical reason?

Please list any medications & conditions taken for?_____

Female patients
❑ Yes ❑ No Using birth control pills?
❑ Yes ❑ No Are you pregnant or is there a chance you are pregnant?

Dental Update

Dentist's name:_____ **Date of last dental appt**_____

❑ Yes ❑ No All current dentistry completed?
❑ Yes ❑ No Any recent injuries to teeth, head, or neck?
❑ Yes ❑ No Any other dental problems or concerns that should be brought to Dr. Kaplan's attention?

If yes, What?_____

_____
Signature of patient **Date** **Doctor's Initials** **Date**

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