Mongillo Orthodontics, PLLC
250 S Skyline Dr, #4
Idaho Falls, ID 83402
Phone: 208-524-1404
info@mongilloortho.com

PATIENT INFORMTION

LAST NAME	FIRST NAME and "preferred"		BIRTH DATE		SSN	SEX
MAILING ADDRESS	CITY		STATE	ZIP	PHONE [ ] check if landline	
HOBBIES/INTERESTS	PREFERRED EMAIL					
HOW DID YOU FIRST HEAR OF OUR OFFICE?	SCHOOL or EMPLOYER		NAME OF DENTIST			

PARENT INFORMATION (please complete if patient is a minor)

MOTHERS NAME [ ] check if primary contact for minor	BIRTH DATE	FATHERS NAME [ ] check if primary contact for minor	BIRTH DATE
ADDRESS [ ] check if same as patient		ADDRESS [ ] check if same as patient	
CITY ST ZIP		CITY ST ZIP	
PHONE [ ] check if landline	WORK PHONE	PHONE [ ] check if landline	WORK PHONE
EMAIL ADDRESS		EMAIL ADDRESS	
EMERGENCY CONTACT NAME ER CONTACT PHONE		EMERGENCY CONTACT NAME ER CONTACT PHONE	
IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?		MAY PATIENT INFORMATION BE RELEASED TO NON-CUSTODIAL PARENT?	

INFORMATION ABOUT RESPONSIBLE PARTY (if different than above)

LAST NAME	FIRST NAME	RELATIONSHIP	SS NUMBER	SEX	BIRTH DATE
ADDRESS	CITY	STATE	ZIP	PHONE [ ] check if landline	

MEDICAL AND DENTAL HISTORY (please check yes or no for each item)

Y N		Y N	
[ ] [ ]	JOINT PROSTHESIS: (Describe)	[ ] [ ]	HAS ANOTHER ORTHODONTIST BEEN CONSULTED PREVIOUSLY?
[ ] [ ]	KIDNEY OR LIVER PROBLEMS: (Describe)	[ ] [ ]	DENTAL ANXIETY
[ ] [ ]	HEART TROUBLE: (Describe)	[ ] [ ]	UNRESOLVED DENTAL ISSUES
[ ] [ ]	ALLERGY: (Describe)	[ ] [ ]	JAW DISCOMFORT / FREQUENT HEADACHES
[ ] [ ]	OSTEOPOROSIS: (List any meds)	[ ] [ ]	ORAL HABIT: THUMB / LIP SUCKING
[ ] [ ]	DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL WORK?	[ ] [ ]	SPEECH THERAPY
[ ] [ ]	SERIOUS ILLNESS: (Explain)	REASON FOR SEEKING ORTHODONTIC CARE?	
[ ] [ ]	MEDICATIONS: (List and explain)		

To the best of my knowledge, the above information is complete and correct. I authorize the release of my records from Mongillo Orthodontics, PLLC to individuals involved in my dental care. I authorize the release of information relating to insurance claims and for Mongillo Orthodontics, PLLC to submit insurance claims on my behalf. I have reviewed the HIPAA Notice of Privacy Practices for Mongillo Orthodontics, PLLC.

_____ _____

Date Signature (of parent or guardian if patient is a minor)

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PRIMARY INSURANCE DETAILS

PATIENT NAME	
BIRTH DATE	
SSN	
PARENT/SUBSCRIBER	
BIRTH DATE	
SSN	
EMPLOYER	
INS COMPANY	
INS ADDRESS	
INS PHONE #	
INS POLICY #	
INS GROUP #	

PRIMARY INSURANCE BENEFITS (office use only)

ORTHO BENEFITS?	Y N
WAITING PERIOD?	Y N
EFFECTIVE DATE	
AGE LIMIT	
LIFETIME MAX	
LIFETIME REMAINING	
DEDUCTIBLE	
IN-NETWORK ALLOWED	
OUT-OF-NETWORK ALLOWED	
% PAID	
% PAID AT BONDING	
PAY OUT/BILL FREQUENCY	MONTHLY QUARTERLY ANNUALLY
CHECK SENT TO	SUBSCRIBER PROVIDER
% PAID ON D1515 / D1525	
ALLOWED ON D1515 / D1525	
NOTES	

SECONDARY INSURANCE DETAILS

BIRTH DATE	
BIRTH DATE	
SSN	
PARENT/SUBSCRIBER	
BIRTH DATE	
SSN	
EMPLOYER	
INS COMPANY	
INS ADDRESS	
INS PHONE #	
INS POLICY #	
INS GROUP #	

SECONDARY INSURANCE BENEFITS (office use only)

ORTHO BENEFITS?	Y N
WAITING PERIOD?	Y N
EFFECTIVE DATE	
AGE LIMIT	
LIFETIME MAX	
LIFETIME REMAINING	
DEDUCTIBLE	
IN-NETWORK ALLOWED	
OUT-OF-NETWORK ALLOWED	
% PAID	
% PAID AT BONDING	
PAY OUT/BILL FREQUENCY	MONTHLY QUARTERLY ANNUALLY
CHECK SENT TO	SUBSCRIBER PROVIDER
% PAID ON D1515 / D1525	
ALLOWED ON D1515 / D1525	
NOTES	