BOISE ORTHODONTICS

DR. ANTHONY MONGILLO, DMD MS

Boise Orthodontics, PLLC
4725 N Cloverdale Rd, Ste 101
Boise, ID 83713
Phone: 208-323-4458
Fax: 208-323-6775
info@boise-orthodontics.com

PATIENT INFORMTION

LAST NAME	FIRST NAME	SS NUMBER	SEX	DOB
MAILING ADDRESS	CITY	STATE	ZIP	PREFERRED PHONE
WHO MAY WE THANK FOR RECOMMENDING US?	NAME OF DENTIST	PREFERRED EMAIL		

PARENT INFORMATION (please complete if patient is a minor)

MOTHERS NAME	DOB	FATHERS NAME	DOB
ADDRESS [ ] check if same as patient		ADDRESS [ ] check if same as patient	
CITY ST ZIP		CITY ST ZIP	
CELL PHONE [ ] check if preferred	HOME PHONE [ ] check if preferred	CELL PHONE [ ] check if preferred	HOME PHONE [ ] check if preferred
EMAIL ADDRESS		EMAIL ADDRESS	
EMPLOYER	WORK PHONE	EMPLOYER	WORK PHONE
EMERGENCY CONTACT NAME	ER CONTACT PHONE	EMERGENCY CONTACT NAME	ER CONTACT PHONE

INFORMATION ABOUT RESPONSIBLE PARTY (if different than above)

LAST NAME	FIRST NAME	SS NUMBER	RELATIONSHIP	SEX	DOB
ADDRESS	CITY	STATE	ZIP	CELL PHONE	
IF DIVORCE IS INVOLVED, WHO IS CUSTODIAL PARENT?		MAY PATIENT INFORMATION BE RELEASED TO NON-CUSTODIAL PARENT?			

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 Boise Orthodontics, PLLC to individuals involved in my dental care. I authorize the release of information relating to insurance claims and for Boise Orthodontics, PLLC to submit insurance claims on my behalf. I have reviewed the HIPAA Notice of Privacy Practices for Boise Orthodontics, PLLC.

____________________ Date

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

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PRIMARY INSURANCE DETAILS

PATIENT NAME	
DOB	
SSN	
PARENT/SUBSCRIBER	
DOB	
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

PATIENT NAME	
DOB	
SSN	
PARENT/SUBSCRIBER	
DOB	
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	