Adult Patient Information

About You

Name: _____
First Last Mi

Common name: _____ Sex: ☐M ☐F

Birthdate: _____ Age:_____ S.S.# _____

Phone #:_____ Cell #:_____

Email Address: _____

Address: _____

_____
City State Zip

Employer: _____ Years of Service? _____

Occupation: _____ Work Phone: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered

Hobbies/Interests: _____

Other family members seen by us: _____

Whom may we thank for referring you? _____

Dentist Name: _____ Last Visit:_____

Spouse / Emergency Contact

Name: _____ Relation: _____
First Middle Last

Phone #:_____ Cell #:_____

Person Responsible For Account

Name: _____ Relation: _____

Phone #: (____)_____ Birthdate: ____/____/____

Billing Address: _____

_____
City State Zip

Years There _____ Own Home ☐ Rent Home ☐

☐ Employed ☐ Retired ☐ Unemployment Comp ☐ Other

Occupation ☐ Professional ☐ Sales/Admin ☐ Trade/Tech

☐ None ☐ Service ☐ Military Officer ☐ Enlisted

Orthodontic Insurance

Primary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name: _____ Group #: _____

Policy Owner's Name: _____

Policy Owner's SS/ID#: _____ Birthdate: _____

Relationship to patient: _____

Policy Owner's Employer: _____

Is the patient covered by another Orthodontic Policy? ☐Y ☐N

Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name: _____ Group #: _____

Policy Owner's Name: _____

Policy Owner's SS/ID#: _____ Birthdate: _____

Relationship to patient: _____

Policy Owner's Employer: _____

Insurance Assignment

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the examination, diagnosis and records of treatment rendered to my insurance company.

_____
SIGNATURE DATE

Dental and Medical History

What would you like orthodontics to accomplish? _____

_____

Have you ever been evaluated for orthodontic treatment? ☐Y ☐N

Have you ever had orthodontic treatment? ☐Y ☐N

Have there been any injuries to the face, mouth, teeth or chin? ☐Y ☐N

Do you require antibiotics before dental treatment? ☐Y ☐N

Do you have any missing or extra permanent teeth? ☐Y ☐N

Do you brush your teeth daily? Y N Floss daily? ☐Y ☐N

Have your ever had any pain/tenderness in the jaw joint? ☐Y ☐N

Do you breathe through your mouth? While Awake Y N Asleep ☐Y ☐N

Have there been any problems associated with previous dental treatment? _____

Your current physical health is: ☐ Good ☐ Fair ☐Poor

Physician's Name: _____

Phone # (____) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐Y ☐N

Please explain: _____

Have you ever taken any bisphosphonates such as: Fosmax, Didronel, Boniva, Actonel, Skelid, Zometa (IV), Aredia (IV), or other? ☐Y ☐N

If so, when? (MM/YY thru MM/YY) _____

Have you ever taken Phen-Fen (Redux or Pondimin) ☐Y ☐N

If so, when? (MM/YY thru MM/YY) _____

Please list any prescription/over-the-counter drugs you are currently taking: _____

Do you smoke or use tobacco in any other form? ☐Y ☐N

WOMEN: Are you using a prescribed method of birth control? ☐Y ☐N

Are you pregnant? ☐Y ☐N Week #: _____

Are you nursing? ☐Y ☐N

Are any of the following conditions present?
Please check any conditions that apply.

☐ Abnormal Bleeding/ Anemia	☐ Herpes/ Fever Blisters
☐ AIDS/HIV+	☐ High/Low Blood Pressure
☐ Alcohol/Drug Abuse	☐ Hepatitis
☐ Artificial Bones/Joints/Valves	☐ Hospitalized for any reason
☐ Arthritis	☐ Kidney/Liver Problems
☐ Asthma	☐ Leukemia
☐ Blood Transfusion	☐ Lupus
☐ Cancer/Chemo/Radiation	☐ Mitral Valve Prolapse
☐ Colitis	☐ Pacemaker
☐ Congenital Heart Defect	☐ Psychiatric Problems
☐ Diabetes	☐ Rheumatic/Scarlet Fever
☐ Difficulty Breathing Emphysema	☐ Shingles
	☐ Sickle Cell Disease/Traits
☐ Epilepsy/Seizures/Fainting	☐ Sinus Problems/ Hay Fever
☐ Frequent Headaches	☐ Stroke
☐ Glaucoma	☐ Thyroid Problems
☐ Handicaps/Disabilities	☐ Tonsils/Adenoids Removed
☐ Hearing Impaired	☐ Tuberculosis
☐ Heart Attack/Surgery	☐ Ulcers
☐ Heart Murmur	☐ Venereal Disease
☐ Hemophilia	☐ Visually Impaired

Are you allergic to any of the following?

☐Y ☐N Aspirin	☐Y ☐N Erythromycin	☐Y ☐N Penicillin
☐Y ☐N Codeine	☐Y ☐N Metals/Jewelry	☐Y ☐N Tetracycline
☐Y ☐N Dental Anesthetics	☐Y ☐N Latex	☐Y ☐N Other

Please list any other drug/material allergies: _____

_____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

SIGNATURE of RESPONSIBLE PERSON ON FRONT **DATE**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental/orthodontic services that I may need.

_____

SIGNATURE DATE

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History Update (For later use)

Has there been any change in your health status since your last visit? ☐Y ☐N

If yes, please explain: _____

_____

_____

SIGNATURE DATE

_____

WITNESS DATE