Information Form for Adult Patients

Today's Date _____/_____/_____ CONFIDENTIAL

PATIENT

Title: ☐Mr. ☐Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____ Sex: ☐ Male ☐ Female

First name _____Last name_____ Middle initial _____

I prefer to be called _____ Social Security # _____ - _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Birthdate _____/_____/_____

Home address: Street_____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

E-mail address _____

Occupation _____ Employer _____

CLOSEST RELATIVE

Name of spouse or closest relative _____ Relationship to patient _____

Address (if different than patient address) Street_____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

DENTIST

Name of Dentist _____ City _____ State _____

Date last seen _____/_____/_____ Reason _____

GENERAL INFORMATION

Who/what had the <u>most</u> influence in you contacting our practice? ☐ Friend/family member ☐ Dentist ☐ Hygienist/dental staff

☐ Website/Internet search ☐ Facebook page ☐ Magazine ad ☐ Local banner ☐ Insurance provider ☐ Local event ☐ Other

Have you had any previous orthodontic treatment? _____

Have any other family members been treated in this office? _____ Please name them:_____

MEDICAL HISTORY

For the following questions, use a separate sheet of paper if necessary.

Please list any and all medical conditions with which you have been diagnosed.

_____

Please list any and all medical conditions or events for which you have been hospitalized.

_____

Please list any and all surgical procedures that you have had or are planning to have in the future.

_____

Please list all medications you are currently taking, and why you are taking them.

_____

If there are any medications you have taken in the past, but are not currently taking, please list them below.

_____

Please list any and all allergies. Don't forget allergies to medications, latex, nickel, and local anesthetics.

_____

Have you ever taken intravenous bisphosphonates (such as Zometa, Aredia, or Didronel) or oral bisphosphonates (such as Fosamax, Actonel, Boniva, Skelid, or Didronel) for cancer or bone disorders like Osteoporosis?_____

Do you feel you have "TMJ" (jaw joint) problems?_____Have you ever been treated for "TMJ"?_____

Have you ever had an orthodontic consultation before now?_____

Women: Are you pregnant? _____ Are you trying to become pregnant? _____

PHYSICIAN

Name of physician _____City_____ State_____

Office phone number _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (if different than patient address) Street_____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

E-mail address _____

Social Security # _____ - _____ - _____ Employer_____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate_____/_____/_____

Social Security # _____ - _____ - _____ Relationship to patient _____

Address of Insured (if not listed above) Street_____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____ Work phone _____

Employer _____ Insurance company_____

Insurance phone # _____ Group #_____ ID#_____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't know

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature_____ Date_____/_____/_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature_____ Date_____/_____/_____