Adult Information Form

WELCOME
To assist us in providing the most complete service, please provide the following information and health history.

Date________________________________

PERSONAL INFORMATION

Patient's Name ____
(Circle) Miss Mrs. Mr.

Birth Date ______________________________ Age ___________

Address____

SS# ____

City ____

Dentist ____

Work Phone ____

Who referred you to our office? ______________________________

Employer ____

Person Responsible for Account:______________________________

Home Phone____

Email Address ____

Mobile Phone ____

____

MEDICAL HISTORY

Please check box if patient has or has had:

- ❑ Positive HIV test
- ❑ Joint swelling
- ❑ Bone disorders
- ❑ Heart trouble
- ❑ Rheumatic fever
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Emotional problems
- ❑ Brain injury
- ❑ Kidney or liver involvement
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Asthma
- ❑ Epilepsy
- ❑ Prolonged bleeding
- ❑ Faintness/Dizziness
- ❑ Tonsils removed
- ❑ Adenoids removed
- ❑ Sore throats
- ❑ Tonsillitis
- ❑ Earaches

List any other serious illnesses: ______________________________

List any allergies: ______________________________

List drugs or medications now being taken: ______________________________

Is patient under physician's care presently?______________________________

Reason: ______________________________

Name of physician: ______________________________

Additional comments:______________________________

____

DENTAL HISTORY

Please check box if answer is yes:

- ❑ Any injuries to face, mouth, teeth? (circle)
- ❑ Mouth-breathing when asleep, awake? (circle)
- ❑ More than average amount of decay?
- ❑ Any missing permanent teeth?
- ❑ Any extra permanent teeth?
- ❑ Any teeth removed by extraction?
- ❑ Is there any tongue-thrusting problem?
- ❑ Any speech problems?
- ❑ Any difficulty in swallowing or chewing?
- ❑ Any pain or clicking on opening mouth?
- ❑ Does patient visit dentist regularly?
  Date of last dental visit______________________________
- ❑ Has an orthodontist been consulted previously?
  Reason:______________________________

List any wind instrument played: ______________________________

Sports: ______________________________

What would you like to have orthodontic treatment accomplish?

____

Patient's attitude toward having orthodontics: (circle one)

Wants It Done Does Not Want It Done Does Not Care

Spouse Information

His/ Her Name: ____

Employer:____

Wk#: (_____)______________________________ Ext.:________ SS#:______________________________

Birthdate:____/____/____

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PLEASE COMPLETE OTHER SIDE

PRIMARY DENTAL INSURANCE ONLY

Ortho coverage? ☐ Yes ☐ No If "Yes" complete below

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: (______)____________________

Group # (Plan, Local, or Policy #): ____________________

Policy Owner's Name: ____________________

Relationship to Patient: ____________________

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

Policy Owner's Employer: ____________________

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? ☐ Yes ☐ No If "Yes" complete below

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: (______)____________________

Group # (Plan, Local, or Policy #): ____________________

Policy Owner's Name: ____________________

Relationship to Patient: ____________________

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

Policy Owner's Employer: ____________________

PATIENT AUTHORIZATION – PLEASE SIGN BELOW

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

X ____________________

Signature Date

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 the office, use the services of one or more credit reporting services.

X ____________________

Signature Date

If this office accepts 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.

X ____________________

Signature Date

FOR OFFICE USE ONLY

Insurance Verification

Lifetime Max ________ How much Met? __________ Claim Address: ____________________

____

____

Date: ____________________

How to bill: Mos____ Qtr.____ 6 mos____ Annual____

Effect Date: ____________________

Payer ID ____________________

Ded.: ____________________

Carrier #____________________

FOR OFFICE USE ONLY

Financial Agreement: Fee ____________________ Payment Plan____________________

Consultation Letter Mailed____________________Completion Letter Mailed ____________________