Adult Information Form

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

MARC allen DDS MS ORTHODONTICS

Date_____

PERSONAL INFORMATION

Patient's Name _____ Birth Date _____ Age _____
(Circle) Miss Mrs. Mr.

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:____/____/____

Marc E. Allen, DDS, MS, PA
MEMBER AMERICAN ASSOCIATION OF ORTHODONTISTS
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

Toothmover@Carolina.rr.com
223 Gilead Rd. Huntersville, NC 28078

MARCALLENORTHODONTICS.COM
P:704.875.7999 F:704.875.1998

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

Date: _____

Effect Date: _____

Ded.: _____

Lifetime Max _____ How much Met? _____

How to bill: Mos____ Qtr.____ 6 mos____ Annual____

Payer ID _____

Carrier #_____

Claim Address: _____

_____

_____

FOR OFFICE USE ONLY

Financial Agreement: Fee _____ Payment Plan_____

Consultation Letter Mailed_____Completion Letter Mailed _____