

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 _____ Birth Date _____ Age _____
(Circle) Miss Mrs. Mr.

Address _____ SS# _____

City _____ State _____ ZIP _____ 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:

- | | |
|--|--|
| <input type="checkbox"/> Positive HIV test | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Faintness/Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> 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

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? Yes No If "Yes" complete below

Ortho coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Insurance Co. Phone #: (____) _____

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

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

Policy Owner's Name: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Relationship to Patient: _____

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

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

Policy Owner's Employer: _____

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.

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

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 _____