ORTHODONTIC AQUAINTANCE RECORD-ADULT

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ORTHODONTIC SPECIALIST

PATIENT INFORMATION

DATE ____________________

LAST NAME ____________________ FIRST NAME ____________________ MIDDLE INIT.______ PREFERRED NAME ____________________

BIRTHDATE____________________ AGE ____________________ SEX: ❑ M ❑ F MARITAL STATUS ____________________

MAILING ADDRESS ____________________ CITY____________________STATE____________ZIP ____________

HOW LONG AT THIS ADDRESS? ____________________PREVIOUS ADDRESS ____________________

HOME PHONE ____________________ WORK PHONE____________________ CELL PHONE ____________________

SOCIAL SECURITY NUMBER ____________________EMAIL ____________________

CURRENT EMPLOYER ____________________ OCCUPATION ____________________YEARS EMPLOYED ____________

HAS ANY FAMILY MEMBER OR RELATIVE RECEIVED TREATMENT AT THIS OFFICE? ____________________

DENTIST ____________________WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________

EMERGENCY CONTACT/SPOUSAL INFORMATION

LAST NAME ____________________ FIRST NAME ____________________ MIDDLE INIT. ______ DOB ____________________

RELATIONSHIP TO PATIENT ____________________ SOCIAL SECURITY NUMBER____________________

EMPLOYER____________________ OCCUPATION ____________________ YEARS EMPLOYED ____________

WORK PHONE ____________________ CELL PHONE ____________________ EMAIL____________________

DENTAL/ORTHODONTIC INSURANCE INFORMATION

INSURANCE - PRIMARY

INS. CO NAME ____________________

INS. CO. ADDRESS____________________

____

____

GROUP NUMBER ____________________

POLICY HOLDER NAME ____________________

INSURANCE IDENTIFICATION NO.____________________

POLICY HOLDER BIRTHDATE ____________________

POLICY HOLDER EMPLOYER ____________________

INSURANCE - SECONDARY

INS. CO NAME ____________________

INS. CO. ADDRESS____________________

____

____

GROUP NUMBER ____________________

POLICY HOLDER NAME ____________________

INSURANCE IDENTIFICATION NO. ____________________

POLICY HOLDER BIRTHDATE ____________________

POLICY HOLDER EMPLOYER ____________________

Signature ____ Date ____________________

HAVE YOU CHECKED WITH YOUR CARRIER REGARDING YOUR ORTHODONTIC BENEFITS? ❑ YES ❑ NO

Office Use: E ❑ S ❑

Please Complete Both Sides

Dental History

Why are you interested in orthodontic treatment?______________________________

Have you ever been evaluated for or received previous orthodontic treatment? ❑ Y ❑ N When:__________ By whom: __________

Have you ever been experienced an adverse reaction during or in conjunction with a dental or medical procedure? ❑ Y ❑ N

If yes, please describe: ______________________________

Check (✓) if you have had any of the following:

Mouth or chin injury ❑ Y ❑ N
Dental or facial pain ❑ Y ❑ N
Jaw clicking, locking or noise ❑ Y ❑ N
Mouth breather ❑ Awake ❑ Asleep
Oral habits affecting the mouth or teeth: ❑ Nail biting ❑ Thumb Sucker ❑ Other: __________

Other information about your dental health or previous treatment ______________________________

____

Medical History

Physician's Name ______________________________ Phone __________

Date of last visit __________ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ______________________________

Are you currently under physician care? ❑ Y ❑ N If yes, describe: __________

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates: __________

Have your adenoids or tonsils been removed? ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N Nursing? ❑ Y ❑ N

Have you ever taken the weight loss drugs fenfluramine (Pondimium) or dexphenfluramine (Redux) either alone or in combination with phentermine? ❑ Y ❑ N

Check (✓) if you have had any of the following:

❑ AIDS/HIV Positive
❑ Anemia
❑ Asthma
❑ Atopic (allergy prone)
❑ Blood disease
❑ Cancer
❑ Convulsions/Epilepsy
❑ Cough, persistent
❑ Cough up blood
❑ C-Pap machine
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Food allergies
❑ Headaches
❑ Heart problems/murmur
Describe __________
Premed? __________
❑ Hearing impairment
❑ Hemophilia/abnormal bleeding
❑ Hepatitis A,B,C
❑ Kidney disease or malfunction
❑ Liver disease
❑ Material allergies
(**latex,** wool, metal, chemicals)
❑ Respiratory disease
❑ Rhuematic/Scarlet fever
❑ Shortness of breath
❑ Sinus problems
❑ Skin rash
❑ Sleep Apnea
❑ Spina Bifida
❑ Thyroid disease or malfunction
❑ Tonsillitis
❑ Tuberculosis
❑ Other __________

Please describe if you answered yes to any of the above: ______________________________

List medications you are taking, if any:

____

____

List drug allergies, if any:

____

____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ______________________________ Date: __________

When appropriate - credit information will be obtained.