

ADULT WELCOME FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (select one)
I prefer to be called:					Single / Mar / Div / Sep / Wid	
Birth date:	/	/	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Email:	
Home address:			SSN:	Home #:		
City:		State:		ZIP:	Cell #:	
Occupation:		Employer:			Work #:	
How long there?		Where & when are the best times to reach you?				
Whom may we thank for referring you?						
Previous/Present Dentist:						
Other family members seen here:			Person Responsible for Account:			
SPOUSE INFORMATION						
His/Her Name:		Birth date:		/	/	SSN#:
Employer:			Work #:			
Emergency contact information:						
His/Her Name:			Relation:			
Home #:			Work #:			
ORTHODONTIC INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
PRIMARY INSURANCE:						
Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Company Name:			Insurance Company Phone #:			
Insurance Co. Address:		City:		State:	ZIP:	
Group #:	Insured Name:		Relation:		Insured DOB:	
Insured's ID #:			Insured's Employer:			
SECONDARY INSURANCE:						
Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Company Name:			Insurance Company Phone #:			
Insurance Co. Address:		City:		State:	ZIP:	
Group #:	Insured Name:		Relation:		Insured DOB:	
Insured's ID #:			Insured's Employer:			
<p>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. I authorize payment of my group insurance benefits to be made directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations, to my insurance company.</p>						
Signature:			Date:			

MEDICAL HISTORY		
Do you have a personal physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician's Name: _____		
Phone #: _____		
Your current physical health is:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Are you currently under the care of a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain: _____		
Do you smoke or use tobacco of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any metal rods, pins or implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you taking any prescription/over-the-counter drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list each one: _____		
For women: Are you taking birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you pregnant? Week #:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any of the following diseases or medical problems:		
Y N Abnormal bleeding/Hemophilia	Y N High Blood Pressure	
Y N AIDS	Y N HIV	
Y N Anemia	Y N Hospitalized for any reason	
Y N Arthritis	Y N Kidney Problems	
Y N Artificial bones/Joints/Valves	Y N Liver Disease	
Y N Asthma	Y N Low Blood Pressure	
Y N Blood Transfusion	Y N Lupus	
Y N Cancer/Chemotherapy	Y N Mitral Valve Prolapse	
Y N Congenital Heart Defect	Y N Pacemaker	
Y N Diabetes	Y N Psychiatric Problems	
Y N Difficulty Breathing	Y N Radiation Treatment	
Y N Emphysema	Y N Rheumatic/Scarlet Fever	
Y N Epilepsy	Y N Seizures	
Y N Fainting Spells	Y N Shingles	
Y N Frequent Headaches	Y N Sickle Cell Disease/Traits	
Y N Glaucoma	Y N Sinus Problems	
Y N Hay Fever	Y N Stroke	
Y N Heart Attack/Surgery	Y N Thyroid Problems	
Y N Heart Murmur	Y N Tuberculosis (TB)	
Y N Hepatitis	Y N Ulcers	
Y N Herpes/Fever Blisters	Y N Venereal Disease	
List any serious medical condition(s) that you have ever had: _____ _____		
Are you allergic to any of the following?		
Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other
List any other drugs/materials you are allergic to: _____ _____		

DENTAL HISTORY	
What are the main orthodontic concerns you would like to accomplish? _____	
Have you ever had or been evaluated for orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had previous orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when? _____	
Have you ever had a serious/difficult problem associated with any previous dental work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your current dental health is:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Have you ever had injury to your (select one):	Mouth Teeth Chin
Do you have any speech problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you generally breathe through your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please circle: While Awake While Asleep	
Are you happy with the way your smile looks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not, what would you change? _____ _____	
I understand that the information 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 that 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. 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 credit reporting services.	
Signature _____	Date _____
OFFICE USE ONLY	
Doctor's Comments: _____ _____ _____	

This office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read the Notice of privacy practices for the above named practice.

Signature _____ Date: _____