# WELCOME – Adult Orthodontic

To assist us in providing the most comprehensive care, please provide the following information.

## PERSONAL INFORMATION

Name: ______________________________________________________________________________
First Middle Last

Home Address: ________________________________ City: ________________ State: ______ Zip: ______

Email: ____________________ Home Phone #: (_____) ______________ Cell #: (_____) ______________

Date of Birth: _____/______/ _____ Age: _____ Sex: ________ Social Security #: _____________

Emergency Contact: ________________________________ Phone #__________________

How did you hear about our office? ____________________________________________________________

## INSURANCE INFORMATION

Policy Holder: _____________________________________________________

Date of Birth: ______________________ Social Security #: ______________________

Member ID # : ______________________ Group #: ___________________________

Employer Name and Address: ________________________________________________________________

Relationship to Patient: ___________________________

Name of Insurance Company: _______________________ Telephone # of Insurance Company: (_____) __________

Address to send Dental Claims: ________________________________________________________________

## AUTHORIZATION

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of changes in medical status.

**Adult Consent:**
I am the patient, ________________________, and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services.

**Insurance Assignment and Release:**
I certify that I am covered by insurance with ____________________________ and assign directly to A Smile 4 U all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

**A Smile 4U** may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.*

__________________________________________________ ____________________
Signature of Patient, Guardian or Personal Representative Date

__________________________________________________ ____________________
Please print name of Patient, Guardian or Personal Representative Date

**PLEASE COMPLETE BOTH SIDE**

## *PATIENT MEDICAL HISTORY*

**Patients Physician:** ______________________________________________ Phone #: ______________________
Date of last physical examination: ____________ Are you currently under the care of a physician? Yes No
If yes, explain: ______________________________
**For Women:** Are you taking birth control pills? Yes No / Are you pregnant? Yes No - Due Date: ________ / Are you nursing? Yes No

**Please list current prescription medications**:

__________________________________________________________________________________________

__________________________________________________________________________________________

Y N Have you ever taken (currently or previously) bone loss prevention medication such as Fosamax, Actonel, or Boniva?

**Are you allergic to any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Y N Aspirin | Y N Amoxicillin | Y N Augmentin | Y N Biaxin | Y N Codeine | Y N Dental Anesthetics |
| Y N Erythromycin | Y N Ibuprofen | Y N Keflex | Y N Latex | Y N Metals | Y N Omnicef |
| Y N Penicillin | Y N Sulfa | Y N Tetracycline | Y N Zithromax | | |

Other if not listed: __________________________________________________________________________

**Do you currently have or have you had the following:**

Y N ADD/ADHD
Y N Alcohol/Drug Dependency
Y N Anemia
Y N Anorexia/Bulimia
Y N Artificial Joint(s) (hip/knee)
Y N Asthma
Y N Autism/Asbergers
Y N Bleeding Abnormally with Extraction
Y N Blood Disease
Y N Cardiac Pacemaker
Y N Cancer / Chemotherapy / Radiation Treatment
Y N Congenital Heart Defect
Y N Cough (Chronic)
Y N Cold Sores/Fever Blisters
Y N Diabetes
Y N Emphysema
Y N Environmental Allergies
Y N Epilepsy or Seizures
Y N Fainting
Y N Headaches (Frequent)
Y N Hearing Concerns
Y N Heart Attack History
Y N Heart Disease/Angina
Y N Heart Murmur
Y N Heart Surgery
Y N Heart Valve Defect
Y N Hemophilia/Blood Transfusion
Y N Hepatitis (A, B, C) / Liver Disease
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Nervousness/Anxiety
Y N Pre-Medication (Antibiotic before Dental)
Y N Psychiatric Care
Y N Respiratory Disease
Y N Rheumatic/Scarlet Fever
Y N Chicken Pox/Shingles
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Sickle Cell Disease
Y N Sinusitis
Y N Smoke or use tobacco
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis

## *PATIENT DENTAL HISTORY*

Do you currently have or have you had the following?

Y N Thumb or Finger Sucking (presently)
Y N Thumb or Finger Sucking (previously)
Y N Had Primary Teeth Removed
Y N Had Permanent Teeth Removed
Y N Speech Concerns
Y N Swallowing Concerns
Y N Injury to Face and/or Teeth
Y N Nighttime Teeth Grinding
Y N Clicking or Pain When Opening Jaws
Y N Headaches/Neck Aches
Y N Sore Muscles (neck/face)
Y N TMJ Symptoms

What are your chief concerns regarding orthodontic treatment:

______________________________________________

______________________________________________

Please describe reasons for considering orthodontic treatment:

______________________________________________

______________________________________________

Recent Dental Check-up/Cleaning
Date: __________ By Whom: ______________________

Previous Orthodontic Treatment
Date: __________ By Whom: ______________________

Previous Examination by an Orthodontist:
Date: __________ By Whom: ______________________

**DR. HAS REVIEWED THE PATIENT MEDICAL & DENTAL/ ORTHODONTIC HISTORY**

**DR'S INITIALS** ________________

**DATE** ______________________