ORTHODONTIC Arts

Adult Patient Information Form

FOREST BEDFORD
FARMVILLE KEYSVILLE
MADISON HEIGHTS
434-385-4499

Tell Us About Yourself

Today's Date: _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev.

Last Name: _____ First Name: _____ Middle Name/Initial: _____

I prefer to be called: _____ ☐ Male ☐ Female Birthdate: _____ Age: ____ SSN: _____

Email Address: _____ Home Phone: (___) _____ Cell Phone: (____) _____

Street Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: (___) _____

Employer's Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Name of spouse/closest relative to contact in case of an emergency: _____ Relation: _____

Work Phone: (____) _____ Cell Phone: (____) _____ Home Phone: (___) _____

General Information

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Whom may we thank for referring you? _____

Name of Dentist: _____ Phone: (___) _____

Date Last Seen: _____ Reason: _____

Have you had a previous orthodontic examination or treatment? ☐ Yes ☐ No

Names of other family members we have treated: _____

Name of Physician: _____ Phone: (___) _____

Date Last Seen: _____ Reason: _____

Account & Insurance Information

Who is financially responsible for the account? _____

Address (if different than patient's): _____

Home Phone: (____) _____ Cell Phone:(____) _____ SSN: _____

Email address: _____

Insurance Coverage for Dental Treatment? Yes ☐ No ☐ Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____ Birthdate: _____

ID# _____ Group #: _____

Insurance Co. Name: _____ Insurance Address: _____

Insurance Phone: (____)_____ Employer: _____

Secondary Policy Holder's Name: _____ Birthdate: _____

ID# _____ Group #: _____

Insurance Co. Name: _____ Insurance Address: _____

Insurance Phone: (____)_____ Employer: _____

Medical History

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Now or in the past, have you had:

☐ yes ☐ no ☐dk/u Birth defects or hereditary problems?

☐ yes ☐ no ☐dk/u Rheumatoid or arthritic conditions?

☐ yes ☐ no ☐dk/u Endocrine or thyroid problems?

☐ yes ☐ no ☐dk/u Kidney problems?

☐ yes ☐ no ☐dk/u Diabetes?

☐ yes ☐ no ☐dk/u Cancer, tumor, radiation treatment, or chemotherapy?

☐ yes ☐ no ☐dk/u Stomach ulcer or hyperacidity?

☐ yes ☐ no ☐dk/u Polio, mononucleosis, tuberculosis or pneumonia?

☐ yes ☐ no ☐dk/u Problems of the immune system?

☐ yes ☐ no ☐dk/u AIDS or HIV positive?

☐ yes ☐ no ☐dk/u Hepatitis, jaundice or liver problems?

☐ yes ☐ no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?

☐ yes ☐ no ☐dk/u Mental health disturbance or behavioral problem?

☐ yes ☐ no ☐dk/u Vision, hearing, tasting or speech difficulties?

☐ yes ☐ no ☐dk/u History of eating disorder (anorexia, bulimia)?

☐ yes ☐ no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐ yes ☐ no ☐dk/u High or low blood pressure

☐ yes ☐ no ☐dk/u Chest pain, shortness of breath or swelling ankles?

☐ yes ☐ no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease?

☐ yes ☐ no ☐dk/u Frequent headaches, colds or sore throats?

☐ yes ☐ no ☐dk/u Eye, ear, nose or throat condition?

☐ yes ☐ no ☐dk/u Hayfever, asthma, sinus trouble or hives?

☐ yes ☐ no ☐dk/u Tonsil or adenoid conditions?

☐ yes ☐ no ☐dk/u Osteoporosis?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐dk/u Local anesthetics (Novocaine or Lidocaine)

☐ yes ☐ no ☐dk/u Aspirin

☐ yes ☐ no ☐dk/u Ibuprofen (Motrin, Advil)

☐ yes ☐ no ☐dk/u Penicillin or other antibiotics

☐ yes ☐ no ☐dk/u Sulfa drugs

☐ yes ☐ no ☐dk/u Codeine or other narcotics

☐ yes ☐ no ☐dk/u Metals (jewelry, clothing snaps)

☐ yes ☐ no ☐dk/u Latex (gloves, balloons)

☐ yes ☐ no ☐dk/u Vinyl

☐ yes ☐ no ☐dk/u Acrylic

☐ yes ☐ no ☐dk/u Animals

☐ yes ☐ no ☐dk/u Foods (specify) _____

☐ yes ☐ no ☐dk/u Other substances (specify) _____

☐ yes ☐ no ☐dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

☐ yes ☐ no ☐dk/u Do you require antibiotic premedication prior to dental procedures?

☐ yes ☐ no ☐dk/u Do you currently have or ever had a substance abuse problem?

☐ yes ☐ no ☐dk/u Do you chew or smoke tobacco?

☐ yes ☐ no ☐dk/u Operations? Describe: _____

☐ yes ☐ no ☐dk/u Hospitalized? For: _____

☐ yes ☐ no ☐dk/u Other physical problems or symptoms?

Describe: _____

☐ yes ☐ no ☐dk/u Being treated by another health care professional?

For: _____

☐ yes ☐ no ☐dk/u Are there any other medical conditions that we should be aware of?

_____

Dental History

☐ yes ☐ no ☐dk/u Any permanent teeth removed? (specify which)

_____

☐ yes ☐ no ☐dk/ Any supernumerary (extra) or congenitally missing teeth? (specify which) _____

☐ yes ☐ no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐ yes ☐ no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐ yes ☐ no ☐dk/u Jaw fractures, cysts or mouth infections?

☐ yes ☐ no ☐dk/u "Dead teeth" or root canals treated?

☐ yes ☐ no ☐dk/u Bleeding gums, bad taste or mouth odor?

☐ yes ☐ no ☐dk/u Periodontal "gum problems"?

☐ yes ☐ no ☐dk/u Food impaction between teeth?

☐ yes ☐ no ☐dk/u Thumb, finger, or sucking habit? Until what age? _____

☐ yes ☐ no ☐dk/u Abnormal swallowing habit (tongue thrusting)?

☐ yes ☐ no ☐dk/u History of speech problems?

☐ yes ☐ no ☐dk/u Mouth breathing habit, snoring or difficulty breathing?

☐ yes ☐ no ☐dk/u Tooth grinding or jaw clenching?

☐ yes ☐ no ☐dk/u Any pain, clicking or locking in jaw or ringing in the ears?

☐ yes ☐ no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?

☐ yes ☐ no ☐dk/u Difficulty encountered in chewing or jaw opening?

☐ yes ☐ no ☐dk/u Have you ever been treated for "TMJ" or "TMD" problems?

☐ yes ☐ no ☐dk/u Aware of loose, broken or missing restorations (fillings)?

☐ yes ☐ no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?

☐ yes ☐ no ☐dk/u Concerned about spaced, crooked or protruding teeth?

☐ yes ☐ no ☐dk/u Aware or concerned about under or over developed jaw?

☐ yes ☐ no ☐dk/u "Gum boils", frequent canker sores or cold sores?

☐ yes ☐ no ☐dk/u Any relative with similar tooth or jaw relationships?

☐ yes ☐ no ☐dk/u Any wisdom tooth problems?

☐ yes ☐ no ☐dk/u Had periodontal (gum) treatment?

☐ yes ☐ no ☐dk/u Any serious trouble associated with previous dental treatment?

☐ yes ☐ no ☐dk/u Been under another dental specialist's care?

☐ yes ☐ no ☐dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

Women Only

☐ yes ☐ no ☐dk/u Are you pregnant?

☐ yes ☐ no ☐dk/u Are you anticipating becoming pregnant?

How often do you brush? _____ Floss? _____

What is your primary concern? Why are you here? _____

Authorization

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I understand that Orthodontic Arts will assist me in filing claims for insurance benefits. I hereby authorize the orthodontist to release all information necessary to secure the payment of insurance benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that Orthodontic Arts does not take responsibility for the recovery of insurance benefits from my insurance carrier and that I am responsible for payment of all services rendered.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)