ROCKWALL ORTHODONTICS

ADULT INFORMATION SHEET

TELL US ABOUT YOURSELF

Today's Date: _____

Name: _____
Ms. Mrs. Mr. Dr. Last First MI

Nickname: _____ ❑ Male ❑ Female

Home Address: _____
Apt./Condo #

_____
City State Zip

E-Mail Address: _____

Hm #: (____) _____ Wk #: (____) _____ Ext: ____

Mobile/Other #: (____) _____

Where & when are the best times to reach you? _____

Birthdate: _____ /_____ /_____ Age: _____ Marital Status: _____

SS#: _____ DL#: _____

Employed By: _____ How Long: _____

Occupation: _____ Job Title: _____

How did you hear about us? _____

Other family members seen by us: _____

General Dentist: _____

Date of last visit: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____ Birthdate: _____ /_____ /_____

SS#: _____ DL#: _____

DID YOU KNOW THAT AGE 7 IS A GOOD TIME FOR A FIRST ORTHODONTIC APPOINTMENT?

Do you have any children who need to be screened? Y N

List children and ages: _____

_____

_____

PERSON RESPONSIBLE FOR ACCOUNT (if other than self)

Name: _____ Relationship: _____

E-Mail Address: _____

Billing Address: _____
Apt./Condo #

_____
City State Zip

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Employer: _____

SS#: _____ DL#: _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Subscriber ID#: _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Subscriber ID#: _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

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MEDICAL HISTORY

Your current physical health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

If yes, please explain:_____

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one:_____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

(Please circle Y or N individually)

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/Aids
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

(Please circle Y or N individually)

Y N Aspirin
Y N Any Metals/Plastics
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: _____

_____

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest of 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.

_____
Signature Date

What are the main concerns that you would like orthodontics to correct?

_____

_____

Have you ever had or been evaluated for orthodontic treatment before? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Have you ever had an injury to your (please circle): Face Mouth Teeth Chin

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Do you have any speech problems? ❑ Yes ❑ No

If yes, please explain:_____

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS?

(Please circle Y or N individually)

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Snoring
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His/Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____) _____

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

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 agencies.

_____
Signature Date

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible(s) that my insurance does not cover.

_____
Signature Date