

Adult Information Form

WELCOME

To assist us in providing the most complete service, please provide the following information and health history.



by Dr. Doleac & Team

Date _____

PERSONAL INFORMATION

Patient's Name _____

(CIRCLE) MISS MRS. MR. MS.

Address _____

City _____ Zip Code _____

Work Phone _____

Employer _____

Dentist _____

Home Phone _____

Mobile Phone _____

Birth Date ____/____/____ Age ____

SS# _____

Person Responsible for Account _____

Email Address _____

MEDICAL HISTORY

Please check box if patient has or has had:

- | | |
|--|--|
| <input type="checkbox"/> Positive HIV test | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Faintness/dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Taking Fosamax (or other biophosphanate for your bones) | |

List any other serious illnesses: _____

List any allergies: _____

List drugs or medications now being taken: _____

Is patient under physician's care presently? _____

Reason: _____

Name of physician: _____

Additional comments: _____

DENTAL HISTORY

Please check box if answer is yes:

- Any injuries to **face, mouth, teeth**? (CIRCLE)
- Mouth-breathing when **asleep, awake**? (CIRCLE)
- More than average amount of decay?
- Any missing permanent teeth?
- Any teeth removed by extraction?
- Is there any tongue-thrusting problem?
- Any speech problems?
- Any difficulty in swallowing or chewing?
- Any pain or clicking on opening mouth?
- Does patient visit dentist regularly?
Date of last dental visit _____
- Has an orthodontist been consulted previously?
Reason: _____

List any wind instrument played: _____

Sports: _____

What would you like to have orthodontic treatment accomplish? _____

Patient's attitude toward having orthodontics: (CIRCLE ONE)
Wants It Done Does Not Want It Done Does Not Care

Spouse Information

His/Her Name _____

Daytime Phone _____

SS# _____

Employer _____

Birth Date ____/____/____

PLEASE COMPLETE OTHER SIDE

PRIMARY DENTAL INSURANCE ONLY

Ortho coverage? Yes No If "Yes" complete below

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth Date _____ / _____ / _____

ID# _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? Yes No If "Yes" complete below

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ / _____ / _____

ID# _____

Policy Owner's Employer _____

How did you find our practice?

- Referred by my dentist, Dr. _____
- Referred by a friend/relative _____
- Yellow Pages
- Internet
- I am a former patient

PATIENT AUTHORIZATION – PLEASE SIGN BELOW

I understand that the information that 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 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

I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I authorize the doctor 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. I authorize the use of this signature on all insurance submissions.

SIGNATURE

DATE