PATIENT FORM (ADULT)

Wilson & Hendrickson ORTHODONTICS

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible!

PATIENT INFORMATION

Name _____ Sex ☐ M ☐ F ☐ OTHER
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

E-mail _____ Birthdate _____
MM/DD/YY

Marital Status _____

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

Dentist _____ Last Visited _____

How did you hear about our practice? ☐ ADVERTISEMENT ☐ FAMILY/FRIEND ☐ INTERNET ☐ DENTIST ☐ OTHER

Who may we thank for referring you to our office? _____

Please list any other family members seen in our office: _____

Emergency Contact Information

Name _____
LAST FIRST MIDDLE

E-mail _____

Primary # _____

DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ Policy Owner's Address _____

Policy Owner's Birth Date _____ Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ Policy Owner's Address _____

Policy Owner's Birth Date _____ Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

MEDICAL AND DENTAL HISTORY

Are you under the care of a physician? ☐ YES ☐ NO If yes, explain: _____

Physician _____ Phone _____ Last Visit _____

Are you pregnant? ☐ YES ☐ NO If so, how many weeks? _____

What are your main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever been evaluated for orthodontic treatment? ☐ YES ☐ NO If yes, explain: _____

Have your tonsils or adenoids been removed? ☐ YES ☐ NO Have you experienced jaw joint pain/discomfort (TMJ/TMD)? ☐ YES ☐ NO

Do you have any missing or extra permanent teeth? ☐ YES ☐ NO

Have you ever had injury to ☐ TEETH ☐ MOUTH ☐ CHIN If yes, explain: _____

Do you have speech problems? ☐ YES ☐ NO If yes, explain: _____

Do your gums bleed? ☐ YES ☐ NO Do you smoke or use electronic cigarettes? ☐ YES ☐ NO Do you like your smile? ☐ YES ☐ NO

Do you have any of the following habits?

☐ LIP SUCKING/BITING ☐ PROLONGED BOTTLE/PACIFIER ☐ MOUTH BREATHER ☐ THUMB/FINGER SUCKING
☐ NAIL BITING ☐ CLENCHING/GRINDING TEETH ☐ TONGUE THRUSTING ☐ CHEWING/EATING PROBLEM

Are you allergic to any of the following?

☐ METALS/PLASTICS ☐ DENTAL ANESTHETICS ☐ LATEX ☐ OTHER

MEDICAL AND DENTAL HISTORY CONTINUED

List all the drugs you are currently taking: This would include prescriptions, diet, or over-the-counter medications. Please include the dosage.

_____

_____

Have you ever taken any medications to strengthen your bones, such as a bisphosphonate? ☐ YES ☐ NO

Please describe any serious medical condition(s): This would include any allergies, serious illnesses, operations, hospitalizations, or surgeries.

_____

_____

Have you ever had any of the following?

- ☐ ADD/ADHD
- ☐ ABNORMAL BLEEDING
- ☐ ANEMIA
- ☐ ARTIFICIAL BONES/JOINTS/VALVES
- ☐ ASTHMA
- ☐ ARTHRITIS
- ☐ BACK PROBLEMS
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ CANCER/CHEMOTHERAPY
- ☐ CHEMICAL DEPENDENCY
- ☐ CIRCULATORY PROBLEMS
- ☐ CONGENITAL HEART DEFECT
- ☐ CORTISONE TREATMENTS
- ☐ PERSISTENT COUGH
- ☐ COUGHING BLOOD
- ☐ DIABETES
- ☐ DIFFICULTY BREATHING
- ☐ EPILEPSY/SEIZURES/FAINTING
- ☐ FEVER BLISTERS/HERPES
- ☐ GLAUCOMA
- ☐ HEART ATTACK/STROKE
- ☐ HEART MURMUR
- ☐ HEART SURGERY/PACEMAKER
- ☐ HEMOPHILIA
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV+/AIDS
- ☐ JAW PAIN
- ☐ KIDNEY PROBLEMS
- ☐ LIVER DISEASE
- ☐ MISTRAL VALVE PROLAPSE
- ☐ PSYCHIATRIC PROBLEMS
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ RHEUMATISM
- ☐ SEVERE/FREQUENT HEADACHES
- ☐ SHORTNESS OF BREATH
- ☐ SICKLE CELL DISEASE/TRAITS
- ☐ SINUS PROBLEMS
- ☐ SKIN RASH
- ☐ SWELLING OF FEET OR ANKLES
- ☐ THYROID PROBLEMS
- ☐ TOBACCO HABIT
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ ULCERS/COLITIS
- ☐ VENEREAL DISEASE

SIGNATURE

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 of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by _____ **Date** _____

Health Insurance Portability and Accountability Act

Through the 1996 Health Insurance Portability and Accountability Act, the Department of Health and Human Services established national standards for among other things, the privacy of protected health information. In compliance with these federal regulations, Wilson & Hendrickson Orthodontics may not discuss your medical care with anyone without your express written permission, except in the case of an emergency or as required by law. This does not apply to disclosing information to carry out treatment, payment, or health care operations.

List below the first and last names and relationship to the patient of people with whom you give Wilson & Hendrickson Orthodontics permission to discuss your case (i.e. medication refills, test results, appointment scheduling, billing information, medical history, etc.)

If you choose not to name anyone, please check 'Yes' ☐ YES

Name _____
LAST FIRST RELATIONSHIP

Name _____
LAST FIRST RELATIONSHIP

Name _____
LAST FIRST RELATIONSHIP

Name _____
LAST FIRST RELATIONSHIP

Name _____
LAST FIRST RELATIONSHIP

Name _____
LAST FIRST RELATIONSHIP