ADULT

WELCOME

We would like to welcome you and your child to our office. In an effort to provide the best possible service, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Social Security# _____ (999-99-9999)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) ext. _____

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

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

Spouse / Additional Contact Information

Name _____ (Last) _____ (First) _____ (Middle) Marital Status

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Birthdate _____ (MM-DD-YYYY) E-mail _____ Relationship to Patient _____

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) ext. _____

Employer _____ Occupation _____ No. Years employed _____

Insurance Information

Policy Owner's Name _____ Policy Owners Social Security # _____ (999-99-9999)

Policy Owner's Birthdate _____ (MM-DD-YYYY) Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Secondary Insurance

Policy Owner's Name _____ Policy Owners Social Security # _____ (999-99-9999)

Policy Owner's Birthdate _____ (MM-DD-YYYY) Relationship to Patient _____

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Medical History

Are you under the care of a physician? Yes No If yes, explain_____
Physician _____ Phone _____ Last Visit _____

Address _____

Are you pregnant Yes No If so how many weeks _____

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

Have you ever been evaluated for orthodontic treatment? _____

Have you tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD) Yes No

Have you had Botox or Dermal Fillers? Yes No Date

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

Have you ever had an injury to: (select all that apply) Teeth Mouth Chin

Do you have speech problems? Yes No if Yes, explain _____

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Any of these occurring?	Lip Sucking/Biting	Nail Biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Finger Sucking

Any allergies?	
Aspirin	Erythromycin
Codeine	Penicillin
Tetracycline	Latex
Any Metals/Plastics	
Other:	

_____

List all drugs you are currently taking

List any serious medical condition(s)

Signature

I understand that the information that I have provided 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 child's 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. I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices.

Signature_____ Date _____

If you would like to be considered for all types of financing, please provide the added information:

How long have you been at current address?_____ Do you own or rent?_____

Previous address (if less than 3 years)_____

Marital Status_____

Additional Helpful Information

Do you have any experience with orthodontic treatment? ie have you had yourself or have any of your kids had orthodontic treatment? If so, please explain:

What is your timeline to begin orthodontic treatment?

1. As soon as possible, I know it is needed.
2. Depends on Doctor's recommendation, but I am ready if needed.
3. I will need some time, if the Doctor feels it is needed, due to the following:
4. Other:

Do you have any friends or family members that come to Acuity Orthodontics? If so, please tell us who:

What is most important when it comes to financing the orthodontic treatment?

1. Financing is not important as I will be paying in full to receive the pay in full discount.
2. I want to make a large down payment, so that I can make my monthly payments low.
3. I will need both a low down payment and low monthly payments as finances are a concern.

Do you have any fear or reservations at dental/doctor visits? If so, please explain:

Thank you for providing the above information so we can provide the best orthodontic care possible. We are honored you have chosen our office for your orthodontic treatment.