

CONFIDENTIAL INFORMATION

Date _____

ADULT PATIENT INFORMATION FORM

Welcome to our Office...

Please assist us by completing the following questions...

Whom may we thank for your referral? _____

PATIENT INFORMATION			
Last Name	First	Middle	Preferred Name
Address			
City	State	Zip Code	
Home Phone	Date of Birth	Age	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> S.S.N.
Employed by	Work Phone		Cell #
Business Address			Occupation
Favorite Sports, Hobbies & Avocations			
Children? Name(s)			Age(s)
Spouse's Name			S.S.N.
Employed by			Work Phone Cell #
Business Address			Occupation
RESPONSIBLE PARTY INFORMATION			
Name of Person Responsible for Account			Relationship to Patient
Home Address (If different than above)			S.S.N.
Employed by			Work Phone Cell #
Business Address			Occupation
INSURANCE INFORMATION			
Primary Insurance Company		Policy Number	
Secondary Insurance Company		Policy Number	
In case we cannot reach you, person(s) to contact			Phone Number

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic treatment. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____

Address: _____ Phone: _____

Are you in good health? Yes No Explain: _____

Do you have a history of a major illness? Yes No Explain: _____

Are you presently under the care of a physician? Yes No Explain: _____

Are you presently taking any medications? Yes No List: _____

Are you allergic or sensitive to any drugs, foods, and metals or other products (ie. latex, nickel)? Yes No List: _____

Have you had surgery that involves the placement of a prosthesis (ie. hip/knee replacement, heart valve replacement)? Yes No Describe: _____

Have you had surgery or radiation treatment for a tumor or growth in the head and neck area? Yes No Describe: _____

If female, are you or might you be pregnant? Yes No

Cont'd.... please complete the reverse side.

Please check if you have had any of the following conditions:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> HIV Positive/AIDS | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> High/Low B.P. | <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Polio | <input type="checkbox"/> Bone Disorders |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Rheumatic Heart Dis. | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Degenerative Joints | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Anorexia Nervosa |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Muscular Disorder |
| <input type="checkbox"/> Heart Trouble/Surgery | <input type="checkbox"/> Lupus/CT Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Heart Valve Defects | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Other _____ |

COMMENTS: _____

DENTAL HISTORY

Dentist's Name: _____
Address: _____ Phone: _____

Please check any of the following conditions for which you have been diagnosed or treated:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Facial/Teeth/Jaw Injury | <input type="checkbox"/> Tongue Thrust | <input type="checkbox"/> Dead Teeth/Root Canal | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> TMJ/TMD/Jaw Problems | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Tooth Sensitivity | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Impacted Teeth |
| <input type="checkbox"/> Grinding/Clenching Habit | <input type="checkbox"/> Receding | <input type="checkbox"/> Chipped or Broken Teeth | <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Receding Jaw |
| <input type="checkbox"/> Jaw Clicking/Popping | <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Thumb or finger habit | <input type="checkbox"/> Jaw Cysts/Tumors | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Jaw Locking | <input type="checkbox"/> Lip Habit | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Other _____ |

COMMENTS: _____

Which of the following are significant concerns?

- | | | |
|--|---|---|
| <input type="checkbox"/> Crooked/Crowded Teeth | <input type="checkbox"/> Over Developed Jaw | <input type="checkbox"/> Missing Teeth |
| <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Tooth Wear | <input type="checkbox"/> Protruding Teeth |
| <input type="checkbox"/> Spaced Teeth | <input type="checkbox"/> Extra Teeth | <input type="checkbox"/> Overbite |
| <input type="checkbox"/> Under Developed Jaw | <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Other _____ |

What would you change about your teeth or smile? _____

Have you had a prior orthodontic exam or prior orthodontic treatment? Yes No
Are you currently under a general dentist's care? Yes No
When was your last dental exam and cleaning? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?
If so, please explain: _____

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.

Signature of Patient or Guardian Date

CONSENT FOR DIAGNOSTIC RECORDS

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

Signature of Patient or Guardian Date

INSURANCE AUTHORIZATION

I agree to be responsible for dental services and materials not paid by my dental benefit plan and to the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signature of Patient or Guardian Date

CONSENT FOR WEBSITE PHOTO

I consent to having my picture displayed on the busbywebb.com website.

Signature of Patient or Guardian Date