Adult's Form

MULLINS ORTHODONTICS

Please fill out this form completely on front and back

TELL US ABOUT YOURSELF

Today's Date: _____

Email Address:_____

Name:_____

Last First Mi Mr Mrs Ms Dr

I preferred to be called:_____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS #:_____

Home Address: _____

_____

Hm #:(_____)_____ Cell #:(_____)_____

Wk #:(_____)_____Ext:_____ DL #:_____

Employer:_____

Employer's Address:_____

_____

Occupation:_____ How long there?_____

Where & when best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us?_____

General Dentist:_____

Last Visit Date:_____

SPOUSE INFORMATION

His/Her Name:_____

Employer:_____

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

Person Responsible for Account:_____

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

Billing Address:_____

Relation:_____ SS #:_____

Employer:_____ DL #:_____

ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(_____) _____

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

Insured's Name:_____ Relation:_____

Insured's Birthdate:____/____/____ Insured's ID #:_____

Insured's Employer:_____

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(_____) _____

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

Insured's Name:_____ Relation:_____

Insured's Birthdate:____/____/____ Insured's ID #:_____

Insured's Employer:_____

Emergency Contact

His/Her Name:_____ Relation:_____

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

Cell #:(_____)_____

MEDICAL HISTORY

Are you presently ill or under the care of a Physician?

☐ Yes ☐ No

Physician's Name:_____

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

MULLINS ORTHODONTICS

PATIENT & MEDICAL HISTORY

What main concerns would you like orthodontics to accomplish?
_____

_____

_____

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

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

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

Do you like your smile? ☐ Yes ☐ No

Your gums ever bleed? ☐ Yes ☐ No

Any previous injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems:_____

Do you generally breathe through your mouth? ☐ Yes ☐ No
If yes, please circle: While Awake? While Asleep?

Do you have missing/extra permanent teeth? ☐ Yes ☐ No

Ever taken Fosamax or any other bisphosphonate? ☐ Yes ☐ No

Ever taken Phen-Fen? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

I understand that the information 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 the diagnosis and treatment with my informed consent.

Have you ever had any of the following diseases or medical problems?

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

Are you taking any prescription/over-the counter drugs? ☐ Yes ☐ No
Please list each one:_____
_____

FOR WOMEN: Using a prescribed method of birth control? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Week #_____

Are you Nursing? ☐ Yes ☐ No

Anything you would like to discuss with Doctor in private? ☐ Yes ☐ No

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

Are you allergic to any of the following?

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

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

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

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____
Signature Date

~ OFFICE USE ONLY ~

I have verbally reviewed the medical/dental information above with the patient named herein. Initials:_____ Date:_____

Doctor's Comments:_____
_____
_____