ORTHODONTICS by DR. BURSON

ADULT FORM

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A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____ ☐Male ☐Female

Patient's Name: _____
Last First Middle

Date of Birth: _____ Age: _____ SSN: _____

Home Address: _____
Street City Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Drivers License No.: _____

Email Address: _____

Employer: _____

Employer Address: _____
Street City Zip

Years Employed: _____ Occupation: _____

When are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

☐Previous ☐Present Date of last visit: _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

His/Her Name: _____

Relationship: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work Phone: _____ Ext: _____

Date of Birth: _____ Age: _____ SSN: _____

Person Responsible for Account: _____

Work Phone: _____ Home Phone: _____

Billing Address: _____

Relation: _____ SSN: _____

Employer _____ Drivers License No.: _____

ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: ☐Y ☐N Dental Coverage: ☐Y ☐N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone No.: _____

Group No. (Plan, Local or Policy No.): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID No.: _____

Insured's Employer: _____

SECONDARY

Orthodontic Coverage: ☐Y ☐N Dental Coverage: ☐Y ☐N

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone No.: _____

Group No. (Plan, Local or Policy No.):

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID No.: _____

Insured's Employer: _____

DENTAL HISTORY

What would you like orthodontics to accomplish? _____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐Y ☐N

Have you ever had a serious/ difficult problem associated with any previous dental work? ☐Y ☐N

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ / TMD)? ☐Y ☐N

Your current dental health is: Good Fair Poor

Do you like your smile? ☐Y ☐N

Have you ever had an injury to your: ☐Mouth ☐Teeth ☐Chin

Indicate any speech problems: _____

Do you breathe through your mouth? ☐Y ☐N

Do you have any missing or extra permanent teeth? ☐Y ☐N

Have you ever taken Fosamax or any other bisphosphonate? ☐Y ☐N

Have you ever taken Phen-Fen? ☐Y ☐N

Do you smoke or use tobacco in any form? ☐Y ☐N

CONTINUED ON BACK

MEDICAL HISTORY

Do you currently have a personal physician? ☐Y ☐N

Physician's Name: _____

Phone No.: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Please explain: ☐Y ☐N

Are you taking any prescriptions / over-the-counter drugs? ☐Y ☐N

Please list each one: _____

WOMEN: Are you using a prescribed method of birth control? ☐Y ☐N

Are you pregnant? ☐Y ☐N Week No.: _____

Are you nursing? ☐Y ☐N

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

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

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

Are you allergic to any of the following?

☐Y ☐N	Aspirin	☐Y ☐N	Latex
☐Y ☐N	Codeine	☐Y ☐N	Penicillin
☐Y ☐N	Metals / Plastics	☐Y ☐N	Tetracycline
☐Y ☐N	Dental Anesthetics	☐Y ☐N	Other
☐Y ☐N	Erythromycin		

Please list any other drug/ material allergies: _____

INFORMED CONSENT

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

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____
SIGNATURE DATE

If this office accepts insurance, 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

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.

OFFICE USE ONLY

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

Doctor's Comments: _____