alexandria braces

Adult Medical and Dental History

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical and dental history form. This information is, of course, confidential.

Patient First Name:_____Patient Last Name:_____

Date of Birth:_____Phone Number:_____Today's Date:_____

If you are completing this form for another person, what is your relationship to that person?

Your Name:_____Relationship:_____

Medical History

Current Physician:_____

Physician's Phone Number:_____Date of last visit:_____

Your current physical health is: Good Fair Poor

Have you ever had any of the following medical problems?

Abnormal Bleeding	Y	N	Handicaps/Disabilities	Y	N
Artificial Bones/Joints	Y	N	Hearing impairment	Y	N
Arthritis	Y	N	Heart Problems	Y	N
Asthma	Y	N	Hepatitis	Y	N
Blood Pressure Problems	Y	N	HIV+/AIDS	Y	N
Cancer/Chemo/Radiation	Y	N	Kidney/Liver defects	Y	N
Chicken Pox	Y	N	Mitral Valve Prolapse	Y	N
Convulsions/Epilepsy	Y	N	Psychiatric Treatment	Y	N
Diabetes	Y	N	Rheumatic/Scarlet Fever	Y	N
Difficulty Breathing	Y	N	Shingles	Y	N
Fainting Spells	Y	N	Sinus Problems	Y	N
Fever Blisters/Cold Sores	Y	N	Tuberculosis	Y	N

For Women:

Are you taking birth control pills? Y N
Are you pregnant? Y N
If yes, Week #:_____
Are you nursing? Y N

Are you allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N

Any metals	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Erythromycin	Y	N

Other:_____

Have you ever used or currently use tobacco products? Y N

___ Cigarettes ___Cigars ___Pipe ___Chew

How much?_____ How often?_____

Do you drink alcoholic beverages? Y N

How much?_____ How often?_____

Dental History

How many months has it been since your last dental check-up?_____

Have you ever had a negative dental experience? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you been evaluated or had orthodontic treatment? Y N

Have you ever injured your face, mouth, teeth, or chin? Y N

Have your adenoids or tonsils been removed? Y N

Do you have any missing, extra, or impacted teeth? Y N

Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)? Y N

Do you take any prescriptions or OTC drugs? Y N

If yes, please list each one:_____
_____
_____

Have you ever taken bisphosphonate drugs (Fosamax, Boniva, etc. used to treat osteoporosis or multiple myeloma)? Y N

Please elaborate on any dental or orthodontic concerns and any additional medical concerns:
_____
_____
_____

I hereby state that the information on this form is true and is correct to the best of my knowledge I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication

Signature:_____ Date:_____

Orthodontist Signature:_____Date:_____

Adult Registration History

We are pleased to have chosen us to provide your oral health care. Be assured that our staff of professionals is current on all techniques of dentistry and are committed to providing you with the highest quality dental care in the most gentle, efficient and enthusiastic manner possible.

Sex: ___ Male ___ Female

Name: _____Date of Birth:_____

Address:_____Zip Code:_____S.S NO:_____

Cell Phone #:_____Cell Phone Carrier:_____

Work Phone #:_____Email Address:_____

Your Employer:_____ Occupation:_____

Employer Address:_____Employer Phone#:_____

Parent/Spouse Name:_____Phone #:_____

Spouse Employer:_____ Occupation:_____

Employer Address:_____Employer Phone #:_____

In Case of an Emergency, Who should be notified?_____Phone #:_____

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

Person responsible for payment of account:_____Cell Phone#:_____

Nearest Relative NOT living with you:_____Phone Number #:_____

Date of Last Dental Visit:_____Purpose of Last Dental Visit:_____

Date of Last Routine Cleaning:_____Dentist Name:_____

Dentist 's Phone Number #:_____ Dentist Address:_____

Purpose for Today's Visit:_____

What is/are your main concern(s) about the condition of your teeth:

_____

What would you like to see in your dental practitioner?

_____

I verify that the responses listed above are true and complete. I have read and fully understand the office policy.

_____ _____

(signature) (date)

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Dental Insurance Subscriber Information

(1) PRIMARY SUBSCRIBER INFORMATION If there is no dental insurance, skip to box (3)	
Name:	
Relationship to Patient:	
Address:	
City:	
State, Zip:	
Home Phone:	
Work Phone:	
Cell Phone:	
Birth Date: / /	Sex: M F
Social Security #:	
Employer:	
(2) DENTAL INSURANCE INFORMATION	
Insurance Name:	
Ins. Address:	
Ins. Phone #:	
Group #:	
Member ID #:	
PATIENT INFORMATION	
Name:	Birth Date: / /
(3) RESPONSIBLE PARTY Circle one: MR MRS MS MISS DR Check here if information is the same as the insurance subscriber ___Primary or ___Secondary	
Name:	Home Phone: Cell:
Relationship to Patient:	Work Phone: Email:
Address:	Birth Date: / / Sex: M F
City:	Social Security #:
State, Zip:	Employer:

Your insurance policy is a contract between you and your insurance company. Please familiarize yourself with your insurance benefits, deductibles, annual maximums and lifetime benefits. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If a secondary insurance applies, it will be the patients responsibility to file to that insurance in the event we are a non-participating provider with that plan.

Payment is due at the time of service. Please note there will be a fee for all returned checks. In the event an account balance becomes delinquent and is forced into collections, the patient agrees to pay all cost incurred. Dental, including, but not limited to, court costs and attorney fees. As the patient (or parent of a minor) I verify that the responses listed above are true and complete. I have read and fully understand the office policy.

Any missed appointments without 48 hours notice will result in a $75 charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY SIGNATURE:_____

DATE:_____ STAFF INITIALS:_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices. I have the right to receive a copy upon request.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____
_____
_____
_____
_____
_____

Received By: _____
(Signature of Staff Member)