



MANN
ORTHODONTICS

ADULT PATIENT INFORMATION

Name: _____ Preferred Name: _____

Address: Street _____ City _____ State _____ Zip _____

Male Female Single Married Divorced Birthday: ____ / ____ / ____

Email: _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Occupation: _____ Home Phone: (____) _____

Patient Dentist: _____

Whom may we thank for referring you? _____

Spouse's Name: _____ Spouse's Birthday: ____ / ____ / ____

Spouse's Employer: _____ Cell Phone: (____) _____

Spouse's Occupation: _____ Work Phone: (____) _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Same as above Other: _____

Name: _____

Address: Street _____ City _____ State _____ Zip _____

Email: _____ Birthday: ____ / ____ / ____

Employer: _____ Cell Phone: (____) _____

Occupation: _____ Work Phone: (____) _____

ORTHODONTIC INSURANCE INFORMATION

(Please submit dental insurance card(s) to front desk)

Orthodontic Insurance Company: _____

Insurance Account Holder: _____ SSN or ID#: _____

Insured's Employer: _____ Insured's Birthday: ____ / ____ / ____

Dual Coverage? Yes No

Secondary Orthodontic Insurance Company: _____

Secondary Insurance Account Holder: _____ SSN or ID#: _____

Secondary Insured's Employer: _____ Insured's Birthday: ____ / ____ / ____



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HEALTH HISTORY

Medical History

- Asthma. If so, what medication? _____
- Convulsions/Epilepsy
- Diabetes
- HIV+ or AIDS
- Heart Murmur/Congenital Heart Defect/Pre-Med Needed
- Bisphosphonate Medication
- Hepatitis or Liver Problems
- Operations/stays in hospital
- Prolonged Bleeding/Hemophilia
- Smoking/Tobacco
- Tonsil/Adenoids removed? If yes, when _____
- Pregnant

List any allergies: _____

List any medication: _____

Dental History

- Any injuries to face, mouth, teeth or chin? (circle)
- Thumb/finger/lip sucking habits? (circle)
Continuing Discontinued
- Mouth breathing when asleep or awake? (circle)
- Any known missing or extra permanent teeth?
- Any clenching or grinding of teeth?
Day Night Both
- Any pain, popping or locking on opening or closing jaw movement? (circle)
- Been evaluated or had previous orthodontic treatment?
- Frequent headaches? If yes, headaches per week _____
AM PM
- Any muscle tenderness or stiffness in jaw or neck? (circle)
- Any previous treatment for TMJ or jaw joint problems?
If yes, explain _____

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

PRIVACY CONSENT

Please list the individuals we are allowed to disclose financial and treatment information regarding the patient above.

Name:

Relationship to Patient:

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my medical/dental status. I have read the notice of privacy practices. I authorize the orthodontic staff to perform the necessary dental services (including x-rays) I may need. I understand that if I take an x-ray performed at Smile Orthodontics to another orthodontic office I will be charged. I understand that pictures of my teeth may be used for educational purposes. I understand that all original documents will be stored electronically. If this office accepts the assignment of benefit for my insurance, I understand that I am responsible for payment of services rendered and responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature: _____ Date: ____/____/____