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 the front desk)

Orthodontic Insurance Company: _____

Insurance Account Holder's Legal Name: _____ SSN or ID#: _____

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

Dual Coverage? Yes ☐ No ☐

Secondary Orthodontic Insurance Company: _____

Secondary Insurance Account Holder's Legal Name: _____ 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(s) you are taking: _____

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 of 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 with 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 the office of any changes in my child's medical/dental status. I have read the notice of privacy practices. I authorize the orthodontics staff to perform the necessary dental services (including x-rays) my child may need. I understand that if I take an x-ray preformed Mann Orthodontics to another orthodontic office I will be charged. I understand that all original documents will be stored electronically. I understand that pictures of my teeth may be used for educational purposes. If this office accepts the assignment of benefit for my insurance, I understand that I am responsible for the payment services rendered and responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature: _____ Date: _____/_____/_____