MANN
ORTHODONTICS

PATIENT INFORMATION

Name: _____ Preferred Name: _____

Address: Street _____ City _____ State _____ Zip _____

Male ☐ Female ☐ Birthday: ____/____/____ Patient Home Phone: (____)_____

Patient Dentist: _____ Patient Cell Phone: (____)_____

Whom may we thank for referring you? _____

Please list siblings of the patient (Name/Age)

_____/____ _____/____

_____/____ _____/____

_____/____ _____/____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian ☐ Other:_____

Name: _____ Birthday: ____/____/____

Address: Street _____ City _____ State _____ Zip _____

Email: _____ Cell Phone: (____)_____

Employer: _____ Work Phone: (____)_____

Occupation: _____ Home Phone: (____)_____

Parents Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed ☐

OTHER PARENT/GUARDIAN INFORMATION

Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian ☐ Other:_____ Same as above ☐

Name: _____ Birthday: ____/____/____

Address: Street _____ City _____ State _____ Zip _____

Email: _____ Cell Phone: (____)_____

Employer: _____ Work Phone: (____)_____

Occupation: _____ Home 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 child's 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) my child 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 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 of services rendered and responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature: _____ Date: ____/____/____