MANN
ORTHODONTICS

PATIENT INFORMATION

Name: ______________________________ Preferred Name: ______________________________

Address: Street ______________ City ______________ State ______ Zip ______

Male ☐ Female ☐ Birthday: ____/____/______ Patient's School: ______________________

Patient's Dentist: ______________________________ Patient's Cell Phone: (____) ______________

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: ______________________

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 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: ____/____/______

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? __________________________

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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: ______/______/______