CHAD JOHNSON ORTHODONTICS

ADULT WELCOME FORM

(Please Print)

Today's date:					
PATIENT INFORMATION					
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
I prefer to be called:					Single / Mar / Div / Sep / Wid
Birth date: / /	Age:	Sex: ❑ M ❑ F	Email:		
Home address:	SSN:	Home #:			
City:	State:	ZIP:	Cell #:		
Occupation:	Employer:	Work #:			
How long there?	Where & when are the best times to reach you?				
Whom may we thank for referring you?					
Previous/Present Dentist:					
Other family members seen here:	Person Responsible for Account:				
SPOUSE INFORMATION					
His/Her Name:	Birth date: / /	SSN#:			
Employer:	Work #:				
Emergency contact information:					
His/Her Name:	Relation:				
Home #:	Work #:				
ORTHODONTIC INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
PRIMARY INSURANCE:					
Orthodontic Coverage? ❑ Yes ❑ No	Dental Coverage? ❑ Yes ❑ No				
Insurance Company Name:	Insurance Company Phone #:				
Insurance Co. Address:	City:	State:	ZIP:		
Group #:	Insured Name:	Relation:	Insured DOB:		
Insured's ID #:	Insured's Employer:				
SECONDARY INSURANCE:					
Orthodontic Coverage? ❑ Yes ❑ No	Dental Coverage? ❑ Yes ❑ No				
Insurance Company Name:	Insurance Company Phone #:				
Insurance Co. Address:	City:	State:	ZIP:		
Group #:	Insured Name:	Relation:	Insured DOB:		
Insured's ID #:	Insured's Employer:				

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize payment of my group insurance benefits to be made directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations, to my insurance company.

Signature: *Date:*

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:

Phone #:

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain:

Do you smoke or use tobacco of any kind? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No
Please list each one:

For women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? Week #: ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems:

Y	N	Abnormal bleeding/Hemophilia	Y	N	High Blood Pressure
Y	N	AIDS	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for any reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack/Surgery	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Hepatitis	Y	N	Ulcers
Y	N	Herpes/Fever Blisters	Y	N	Venereal Disease

List any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/materials you are allergic to: _____

_____

DENTAL HISTORY

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

_____

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑ No

Have you ever had previous orthodontic treatment? ❑ Yes ❑ No

If yes, when? _____

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Have you ever had injury to your (circle one): Mouth Teeth Chin

Do you have any speech problems? ❑ Yes ❑ No

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: While Awake While Asleep

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of credit reporting services.

_____

Signature Date

OFFICE USE ONLY

Doctor's Comments: _____

_____

_____

This office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read the Notice of privacy practices for the above named practice.

Signature _____ *Date:* _____