



ADULT PATIENT INFORMATION

Date _____

Name _____ Nickname _____ M/F Age _____ Birthdate _____

Street Address _____

City _____ State _____ Zip _____ E-mail _____

Home telephone _____ Work telephone _____ Cell phone _____

Occupation _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Person responsible for account _____ Soc. Sec. No. _____

Billing address _____

Relationship to patient _____ D.O.B. _____

EMERGENCY CONTACT

Name _____ Relationship _____

Complete Address _____

Home telephone _____ Work telephone _____

The office of Dr. Brady will be happy to process your orthodontic claims.

To successfully process your claims, all of the following information is necessary.

If you do not have all of the required information we suggest you contact your Human Resources Representative and they can help you with any missing information.

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____	Insured's Date of Birth _____
Insurance Co. _____	Soc. Sec. No. _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	Group No. _____

I hereby authorize release of any information relating to my insurance.

Signature: _____ Date _____

I hereby authorize payment of insurance benefits directly to the named orthodontists.

Signature: _____ Date _____

Dual Insurance (if applicable)

Secondary Insured's Name _____	Insured's Date of Birth _____
Insurance Co. _____	Soc. Sec. No. _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	Group No. _____

PERSONAL HISTORY

Please list your hobbies/interests _____



Patient's Name _____

MEDICAL HISTORY

Physician _____ Phone _____

Complete address _____

General Health and Known Illnesses _____

Present Medications _____

Surgery (with Approximate Dates) _____

Is there a possibility that you may be pregnant? _____

Have you ever had an allergic reaction to medication? Yes ___ No ___

If Yes, please list medication _____

Have you ever had an allergic reaction to foods? Yes ___ No ___

If Yes, list food(s) _____

Have you ever had any of the following: Circle YES or NO

Bleeding History	No	Yes	High Blood Pressure	No	Yes
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Cancer	No	Yes	Migraine Headaches	No	Yes
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Diabetes	No	Yes	Stomach Ulcers	No	Yes
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Hearing Loss	No	Yes	Hepatitis	No	Yes
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Epilepsy	No	Yes	Kidney Problems	No	Yes
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Liver Problems	No	Yes	AIDS or other immune system disorder	No	Yes
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Cardiovascular disease (Heart trouble, heart attack, coronary insufficiency, coronary occlusion arteriosclerosis, stroke)	No	Yes
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Damaged heart valves (Mitral valve prolapse, artificial heart valve, heart murmur) or any other conditions which may require you to be premedicated.	No	Yes
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If yes, does your condition require you to be premedicated? _____



Patient's Name _____

DENTAL HISTORY

Patient's Dentist _____ Date of Last Visit _____

Complete address _____

- 1) Have you previously consulted an orthodontist? _____ Yes ___ No ___
If Yes, when? _____
- 2) Is there a family history of congenitally missing teeth? _____ Yes ___ No ___
Yourself _____ Relative(s) _____
- 3) Do your gums bleed when you brush your teeth? _____ Yes ___ No ___
- 4) Is any part of your mouth sensitive to temperature? _____ Yes ___ No ___
Is any part of your mouth sensitive to pressure? _____ Yes ___ No ___
- 5) Have you ever sucked your thumb or finger(s)? _____ Yes ___ No ___
If so, have you stopped this habit? _____ When? _____
- 6) Do you breathe predominantly through your mouth? _____ Yes ___ No ___
- 7) Have you had tonsils/adenoids removed? _____ Yes ___ No ___
If Yes, when? _____
- 8) Do you clench or grind your teeth during the day? _____ Yes ___ No ___
- 9) Have you been made aware of clenching or grinding your teeth during the night? _____ Yes ___ No ___
- 10) Do you now have, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)? _____ Yes ___ No ___
- 11) Have you ever had clicking or popping in your jaw joint? _____ Yes ___ No ___
If Yes, please explain _____
- 12) Have you ever experienced pain when you open wide? _____ Yes ___ No ___
- 13) Have you had any injury to your jaw? _____ Yes ___ No ___
If Yes, please explain _____
- 14) Have you had any injury to your teeth? _____ Yes ___ No ___
If Yes, please explain _____