BRADY
ORTHODONTICS PC

PATIENT INFORMATION FORM

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 _____Cellphone_____

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 Orthodontist.

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 _____

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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? Yes_____No____

Have you ever had an allergic reaction to medication? Yes____ No____

If Yes, please list medication(s)_____

Have you ever had an allergic reaction to foods, latex, any metals, especially **Nickel** or **Titanium,** or any other substance?

Yes_____ No_____ If Yes, please list your allergy(ies) to any of the above mentioned_____

_____

Have you ever had any of the following:	Circle YES or NO				
Bleeding History	No	Yes	High Blood Pressure	No	Yes
Cancer	No	Yes	Migraine Headaches	No	Yes
Diabetes	No	Yes	Stomach Ulcers	No	Yes
Hearing Loss	No	Yes	Hepatitis	No	Yes
Epilepsy	No	Yes	Kidney Problems	No	Yes
Liver Problems	No	Yes	AIDS or other Immune System disorder	No	Yes

Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion arteriosclerosis, stroke) No Yes

Damaged heart valves (Mitral valve prolapse, artificial heart valve, heart murmur) or any other conditions which may require you to be premedicated. No Yes

If yes, does your condition require you to be premedicated?

_____

_____

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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) Have you consulted any other dental specialty? _____ Yes ____No___

If yes, when? _____

3) Is there a family history of congenitally missing teeth? Yes ____No___

Yourself _____ Relative(s) _____

4) Do your gums bleed when you brush your teeth? Yes ____No___

5) Is any part of your mouth sensitive to temperature? Yes ____No___
Is any part of your mouth sensitive to pressure? Yes ____No___

6) Have you ever sucked your thumb or finger(s)? Yes ____No___
If so, have you stopped this habit? Yes ____No___

7) Do you breathe predominantly through your mouth? Yes ____No___

8) Have you had your tonsils/adenoids removed? Yes ____No___

If Yes, when? _____

9) Do you clench or grind your teeth during the day? Yes ____No___

10) Have you been made aware of clenching or grinding your teeth during the night? Yes ___No____

11) 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____

12) Have you ever had clicking or popping in your jaw joint? Yes ____No___

If Yes, please explain _____

13) Have you ever experienced pain when you open wide? Yes ____No___

14) Have you had any injury to your jaw? Yes____No___

If Yes, please explain_____

15) Have you had any injury to your teeth? Yes____No____

If Yes, please explain_____