



ADULT PATIENT INFORMATION

Primary Phone _____

Referred By _____

NP Exam Date _____ Time _____ Location _____

PATIENT: <i>First</i> <i>Middle</i> <i>Last</i>				SEX: ☐ M ☐ F		GENDER: ☐ M ☐ F ☐ _____							
FAMILY MEMBERS WE'VE TREATED:			DATE OF BIRTH: / /		AGE:		SOCIAL SECURITY #:						
EMAIL ADDRESS:													
ADDRESS:					PRIMARY PHONE: ☐ Home ☐ Cell ☐ Work								
CITY:			STATE:		ZIP:		ALT. PHONE: ☐ Home ☐ Cell ☐ Work						
MARITAL STATUS:		SPOUSE'S NAME:		DATE OF BIRTH: / /		AGE:		SOCIAL SECURITY #:					
SPOUSE'S EMAIL ADDRESS:					SPOUSE'S PRIMARY PHONE: ☐ Home ☐ Cell ☐ Work								
Fehrman Orthodontics offers interest-free payment options based on credit worthiness. In order to set up your account at our office, please fill out the following information in its entirety. Your Social Security Number may be needed to obtain credit history, or for filing a claim with your insurance, and will not be disclosed for any other purpose. Please initial that you have read and understand this information. INITIAL: _____													
Fehrman Orthodontics will submit insurance claims on your behalf. Please bring your current dental insurance card(s) with you to your exam and fill out the following information in its entirety. We will verify your orthodontic coverage and provide you with an estimate for treatment based on this information.													
PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE									
DENTAL CARRIER:				DENTAL CARRIER:									
POLICY HOLDER:		DOB:		REL TO PT:		POLICY HOLDER:		DOB:		REL TO PT:			
MEMBER #:		GROUP #:		MEMBER #:		GROUP #:		MEMBER #:		GROUP #:			
EMPLOYER:				EMPLOYER:									
INSURANCE CO. ADDRESS:				INSURANCE CO. ADDRESS:									
CITY:			STATE:		ZIP:		CITY:			STATE:		ZIP:	
INSURANCE CO. PHONE:				INSURANCE CO. PHONE:									
I hereby authorize payment directly to Fehrman Orthodontics.				I hereby authorize payment directly to Fehrman Orthodontics.									
_____ <i>Signature of Insured Person</i>				_____ <i>Signature of Insured Person</i>									
_____ <i>Date</i>				_____ <i>Date</i>									

(Check at least one): HOW DO YOU PREFER TO BE REMINDED OF APPOINTMENTS: ☐ VM ☐ TEXT ☐ EMAIL

I certify the information on this form is true to the best of my knowledge. I accept responsibility for the dental charges incurred. I understand my dental insurance provider may pay less than the actual bill for services and I am ultimately responsible for any balances due. I understand that I am responsible for any late fees, missed appointments and/or collection fees incurred. I acknowledge that Fehrman Orthodontics will provide me with a copy of their Privacy Practices upon request.

Signature of Patient: _____ Date: _____

Patient Name: _____

DENTAL HISTORY

Name of patient's dentist: _____ Date of last dental exam: _____

What is your chief concern for us at this visit? _____

** Please check Yes or No for the following questions, whichever applies. Your answers are for our records only and will be considered confidential.
Please use the space after the questions for additional explanations.

Yes No

- ☐ ☐ Has patient had a previous orthodontic exam
- ☐ ☐ Has patient had any orthodontic treatment
- ☐ ☐ Injury to the mouth or teeth
- ☐ ☐ History of missing or extra teeth
- ☐ ☐ Have any permanent teeth been removed
- ☐ ☐ Have tonsils or adenoids been removed
- ☐ ☐ Mouth breathing habit
- ☐ ☐ Chronic snoring
- ☐ ☐ Thumb or finger habit
- ☐ ☐ Does the patient brush daily
- ☐ ☐ Does the patient floss daily

Yes No

- ☐ ☐ Food getting stuck between teeth
- ☐ ☐ Is water fluoridated
- ☐ ☐ Does the patient grind his/her teeth
- ☐ ☐ Does the patient clench his/her teeth
- ☐ ☐ Has the patient's jaw ever locked
- ☐ ☐ Does the patient have pain in his/her jaw joint
- ☐ ☐ Does the patient experience soreness in the muscles of his/her face or around the ears
- ☐ ☐ Does the patient notice clicking or popping in his/her jaw joint
- ☐ ☐ Frequent headaches / neckaches
- ☐ ☐ Does patient take fluoride supplements

Explain any condition(s) above: _____

MEDICAL HISTORY

Physician: _____ Date of Last Visit _____ [] Pregnant Due: _____
[] Nursing

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Yes No Require premedication prior to dental visits? For what condition? _____

Yes No Taking / have taken bisphosphonates (Fosamax, Actonel, Boniva, Zometa, Aredia, Skelid, Didronel) and medical reason for treatment
(severe bone disorders, cancers or osteoporosis/osteopenia) in past 5 years _____

Allergies or drug reactions to: ☐ Latex ☐ Sulfa drugs ☐ Food allergies: _____
☐ Nickel / Metal ☐ Aspirin, Ibuprofen or Tylenol
☐ Penicillin or other antibiotics ☐ Codiene or other narcotics _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding / Hemophilia	Bone Disorders	Hepatitis / Liver Problems	Rheumatic Fever
Acid Reflux	Congenital Heart Defect	Herpes	Sleep Apnea
ADHD	Diabetes	High Blood Pressure	Speech Difficulty
Anemia	Dizziness	HIV / Aids	Tuberculosis
Arthritis	Epilepsy / Fainting Spells	Kidney Problems	Tumor or Cancer
Asthma or Hayfever	Gastrointestinal Disorders	Nervous Disorders	Vision / Hearing Impaired
Autism	Heart Murmur	Pneumonia	
Blood Disorder	Heart Problems	Radiation / Chemotherapy	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

If so, please explain: _____

BENEFITS

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment without adequate retention. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Fehrman Orthodontics to perform a complete orthodontic evaluation.

Signature of Patient: _____ Date: _____