Adult Information Form

WELCOME
To assist us in providing the most complete service, please provide the following information and health history.

Lake Norman
Orthodontics
WWW.LKNORTHO.COM (https://lknortho.com/)

Date: _____

PERSONAL INFORMATION

Patient's Name: _____ _____ _____ Birth Date: _____ Age: _____

Miss ○ Mrs ○ Mr ○ SS# _____

Address: _____ Dentist: _____

City: _____ State: _____ ZIP: _____ Who referred you to our office? _____

Work Phone: _____ Person Responsible for Account: _____

Employer: _____ Email Address: _____

Home Phone: _____

Mobile Phone: _____

Spouse Information

His / Her Name: _____

Employer: _____

MEDICAL HISTORY

Please check box if patient has or has had:

- ☐ Positive HIV test
- ☐ Joint swelling
- ☐ Bone disorders
- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Emotional problems
- ☐ Brain injury
- ☐ Kidney or liver involvement
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Prolonged bleeding
- ☐ Faintness/Dizziness
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Sore throats
- ☐ Tonsillitis
- ☐ Earaches

List any other serious illnesses: _____

List any allergies: _____

List drugs or medications now being taken: _____

Is patient under physician's care presently? _____

Reason: _____

Have you ever taken any of the following medications: "Fen-phen" or Bisphosphonate drugs for osteoporosis (such as Fosamax, Boniva, Zometa, Actonel, etc.)? (circle)

DENTAL HISTORY

Please check box if answer is yes:

- ☐ Any injuries to face, mouth, teeth? (circle)
- ☐ Mouth-breathing when asleep, awake? (circle)
- ☐ Sleep problems: snoring, restlessness, dark circle under the eyes (circle)
- ☐ More than average amount of decay?
- ☐ Any missing permanent teeth?
- ☐ Any extra permanent teeth?
- ☐ Any teeth removed by extraction?
- ☐ Is there any tongue-thrusting problem?
- ☐ Any speech problems?
- ☐ Any difficulty in swallowing or chewing?
- ☐ Any pain or clicking on opening mouth?
- ☐ Does patient visit dentist regularly?

Date of last dental visit: _____

☐ Has an orthodontist been consulted previously?

Reason: _____

What would you like to have orthodontic treatment accomplish?

_____

PRIMARY DENTAL INSURANCE ONLY

Ortho coverage? Yes ○ No ○ If “Yes” complete below

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner’s Name: _____

Relationship to Patient: _____

Policy Owner’s Birthdate: _____ SS#: _____

Policy Owner’s Employer: _____

SECONDARY DENTAL INSURANCE ONLY

Ortho coverage? Yes ○ No ○

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner’s Name: _____

Relationship to Patient: _____

Policy Owner’s Birthdate: _____ SS#: _____

Policy Owner’s Employer: _____

PATIENT AUTHORIZATION – PLEASE SIGN BELOW

I understand that the information that 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 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.

Signature: _____ Date: _____

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 one or more credit reporting services.

Signature:

_____

If this office accepts insurance, 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.

Date: _____