webb ORTHODONTICS

Adult Information Form
Date: _____

WELCOME

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

Patient Name_____ Birth Date _____ Age _____

Address _____ City_____ State_____ZIP_____

Employer _____ Work Phone _____ SS# _____

Home Phone _____ Mobile Phone _____ E-mail _____

Dentist _____Who can we thank for referring you to us? _____

What is Your Biggest Concern? _____

Describe Your Attitude Towards Treatment (Circle One): I Want it Done Today! I Don't Really Care I'm Not Too Thrilled...

SPOUSE INFORMATION

Name_____Age _____ SS# _____

Employer_____ Phone_____ E-mail _____

Person Responsible for Account_____

PRIMARY DENTAL INSURANCE ONLY

Orthodontic Coverage? 0 Yes 0 No

If "Yes" please complete below:

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insurance Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's DOB_____ SS# _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE ONLY

Orthodontic Coverage? 0 Yes 0 No

If "Yes" please complete below:

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insurance Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's DOB_____ SS# _____

Policy Owner's Employer _____

FOR OFFICE USE ONLY:

% _____ Age _____ Max _____ How much met? _____ WPE: Y N Waiting: Y N

Insurance Verification: Submit or Auto Date_____ Effective Date_____ Deduct. _____

How to bill: Mos_____ Qtr_____ 6 Mos _____ Annual _____ Payer ID _____ Carrier # _____

Michael A Webb DDS, MS
Colin M Webb DDS, MS

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MEDICAL HISTORY

0 Adenoids Removed	0 Anemia
0 Asthma	0 Bone Disorders
0 Birth Abnormalities	0 Diabetes
0 Faintness/Dizziness	0 Epilepsy
0 Earaches	0 Joint Swelling
0 Hepatitis	0 Heart Trouble
0 Emotional Problems	0 Tonsils Removed
0 Endocrine Problems	0 Tonsillitis
0 Sore Throats	0 Prolonged Bleeding
0 Thyroid Problems	0 Rheumatic fever
0 Positive HIV Test	0 Kidney or Liver Disease

List any other serious illnesses:

_____

Allergies to: Latex/Metal/Drugs/Local Anesthetics (circle)

DENTAL HISTORY

0 Any injuries to face, mouth, teeth? (circle)

0 Mouth-breathing when awake, asleep? (circle)

0 More than average amount of decay/cavities?

0 Any missing permanent teeth? _____

0 Any extra permanent teeth? _____

0 Any teeth removed by extraction? _____

0 Is there any tongue-thrusting issues?

0 Any speech difficulties? _____

0 Any difficulty swallowing or chewing?

0 Any pain or clicking on opening/closing mouth? (circle)

0 Does patient visit dentist regularly? Recent Date_____

0 Any previous orthodontic treatment/consultation? (circle)

Reason_____

Current Drugs/Medications_____ Currently Under Physician's Care? 0 Yes 0 No

Physician_____ Reason _____ Comments _____

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.

X _____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.

X _____Date_____

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.

X _____Date_____