WELCOME TO MERGEN ORTHODONTICS
(Adult form)

PATIENT INFORMATION

*Patient's Name: (last) ____________________ (first)__________________ (middle)______________

Preferred Name: _________________________________

*Birth date: _________________ Age: ________ Gender: _____ female _____ male

Spouse: ____ Marital status: _________________________

*Address: _______________________________ City: ________________________ Zip: ____________

Phone: (home)___________________ (work)_____________________ (cell) ______________________

E-mail address: ____

Hobbies and interests: ____

____

Other family members treated here: ____

WHAT is the primary reason for your visit: ____

WHY did you select our office for treatment: ____

WHO may we thank for referring you to our office: ____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (if different from patient)

Name: (last) __________________________ (first) ______________________ (middle) ______________

Address: _______________________________ City: _______________________ Zip: _____________

Phone: (home)___________________ (work)_____________________ (cell) ______________________

S.S.N.: _________________________________

Employer: _____________________________ How many years: ____ City: ______________________

ORTHODONTIC INSURANCE COVERAGE(S)

Insurance coverage for **orthodontic** treatment? _____ (yes) _____ (no)

Insurance coverage for **dental** treatment? _____ (yes) _____ (no)

Primary Policy Holder For Orthodontic Insurance

*Name: (last) __________________________(first) ______________________(middle)______________

*S.S.N. : _____________________________

*Birth Date: __________________________

*Employed by: _____________________________________ City: ______________________

*Dental Insurance Company: ____________________________ Plan: _________________________

*Group No: ____________________________ *Policy No: _________________________________

Secondary Policy Holder For Orthodontic Insurance

*Name: (last) __________________________(first) ______________________ (middle)______________

*S.S.N. : _____________________________

*Birth Date: __________________________

*Employed by: _____________________________________ City: ______________________

*Dental Insurance Company: _____________________________ Plan: ________________________

*Group No: ____________________________ Policy No: __________________________________

***PLEASE MAKE SURE THAT THESE ITEMS ARE FILLED IN SO THAT WE CAN FILE YOUR ORTHODONTIC INSURANCE FOR YOU**

PATIENTS MEDICAL AND DENTAL HISTORY

PATIENT MEDICAL HISTORY

__Y __N Birth defects or hereditary problems?
__Y __N Liver problems?
__Y __N Kidney problems (jaundice, etc.)?
__Y __N Lung problems (asthma, etc.)?
__Y __N Heart problems (defects, strokes, heart attack, high blood pressure, etc.)?
__Y __N Heart valve repair?
__Y __N Heart murmur?
__Y __N Neurological problems?
__Y __N Epilepsy or seizures?
__Y __N Ears, nose, throat conditions?
__Y __N Diabetes?
__Y __N Polio, mononucleosis, or pneumonia?
__Y __N Tuberculosis (TB)?
__Y __N Hepatitis?
__Y __N AIDS or HIV positive?
__Y __N Allergies (Aspirin, Advil, Ibuprofen, Latex, Acrylic, Nickel Metals)

*Please list any allergies:*____

*If you have **answer yes** to any items above please describe the problem.*
____
____
____
____

Please list any medications that you are currently taking, how long and for what:_________________
____

Physicians name: ____ City: _____________________
General Dentists name: ___________________________________ City: _____________________

PATIENT DENTAL HISTORY

__Y __N Permanent or supernumerary (extra) teeth removed?
__Y __N Chipped or injured any teeth?
__Y __N Mouth breathing (breathing mainly through mouth & not nose)?
__Y __N Grinding or clenching teeth? _______night ______ day ________ both
__Y __N Jaw pain or clicking? _______ right ______ left _______ both

PATIENT PROFILE

__Y __N Do you brush and floss routinely?
__Y __N Are you sensitive or self-conscious about your teeth or smile?
__Y __N Do you have concerns about the relationship of your jawbones to your facial appearance?
__Y __N Are having straight teeth and a beautiful smile a high priority to you?

I have read and understand the above questions. If there are any changes later to this medical / dental status, I will inform Mergen Orthodontics. I have read the *Notice of Privacy Practices (HIPAA)* for Mergen Orthodontics and I understand that I may obtain a copy if I so desire.

Signature: ____ Date: ______________