RICHARDS & ASSOCIATES ORTHODONTICS

--ADULT PATIENT INFORMATION--

Patient's Name:______________________________**Age**________**Sex**_______

Social Security #:______________________**Date of Birth:**_________________

Occupation:______________________**Employer:** ________________________

Marital Status:___________**Spouse Name:**______________________________

Mailing Address:____

City:_________________________________**State:**_________**Zip:**___________

Phone Number:___________________**(Mobile, Home, Business-circle one)**

Patient Email Address: ____

Current Dentist:___________________**Dentist Phone #:**__________________

Current Physician:_________________**Physician Phone #:**________________

Who may we thank for referring you to our office?______________________

--INSURANCE INFORMATION--

Orthodontic Insurance? Insurance Name_____________________________

Insurance phone number:____

Employer____

Subscriber Name:_______________________ **Birthdate:**________________

Subscriber ID#:_________________________**Group #:**__________________

PATIENT NAME:____

--MEDICAL HISTORY--

Is the Patient in good health?__________________
Have tonsils and/or adenoids been removed?____
If presently under physician's care, state condition and duration____
____
Does patient have history of major illness/infectious diseases?____
List any high fevers with childhood diseases____
List any drugs or medications being taken and reasons____
____
List any allergies or drug sensitivities (e.g.. penicillin, novacaine)____
List any learning disabilities____
List any birth defects____
List any psychological counseling____
Check any of the following for which you have been treated and give age:

	Yes	No		Yes	No		Yes	No
HIV + Aids………………	[ ]	[ ]	Bone Disorders……….	[ ]	[ ]	Kidney Problems………….	[ ]	[ ]
Fainting/dizziness…..	[ ]	[ ]	Pneumonia or TB…….	[ ]	[ ]	Nasal difficulty…………….	[ ]	[ ]
Diabetes…………………	[ ]	[ ]	Nervous Disorders…..	[ ]	[ ]	Heart Trouble………………	[ ]	[ ]
Epilepsy………………….	[ ]	[ ]	Endocrine Problems..	[ ]	[ ]	Hepatitis…………………….	[ ]	[ ]
Rheumatic Fever……..	[ ]	[ ]	Asthma…………………..	[ ]	[ ]	Prolonged Bleeding……….	[ ]	[ ]
Dermatitis………………	[ ]	[ ]	Facial Fillers/Botox…..	[ ]	[ ]			

Perferred Pharmacy:________________________________**Phone number:**______________________________
____

--DENTAL HISTORY--

Did Father have an orthodontic problem?____**Treated?**__________
Did Mother have an orthodontic problem?____**Treated?**__________
Do any siblings have any orthodontic problems?____________________________________**Treated?**__________
List other family members treated in this office____
List names and ages of other children in family____
Face and mouth most resemble: [ ]Father [ ]Mother [ ]Neither
List any injuries to face, teeth or mouth____
Habits: [ ]Mouth breathing [ ]Grinding teeth [ ]Thumb or finger sucking (until what age)________________
List any speech problems____
List any musical instruments played____
Has an orthodontist been consulted previously: [ ]Yes [ ]No Whom?___________________________________
Does patient vomit , gag or faint easily? [ ]Yes [ ]No
Have you been informed of any missing or extra permanent teeth? [ ]Yes [ ]No_________________________
Is patient especially apprehensive toward dental visits? [ ]Yes [ ]No
When did patient last have dental care?____
By Whom____**When is next scheduled visit?**_______________
What do you feel may be the cause of the orthodontic problem?____
What would you most like to have orthodontic treatment accomplish?____________________________________
Most Important- does the patient want orthodontic treatment? [ ]Yes [ ]No

PATIENTS NAME:____

--AUTHORIZATIONS—

I hereby authorize Richards & Associates Orthodontics to release a copy of my records to any treating physician/dentist, insurance company or other orthodontist, who may request these records pursuant to further medical or orthodontic care or treatment, and hereby release Richards & Levine Orthodontics and staff, from any and all responsibility that may arise from their compliance with this authorization. I hereby authorize Richards & Associates Orthodontics to use any of my x-rays or photographs in medical lectures /publications and for further educational purposes. I understand the Panorex taken at my new patient exam is at no charge but if the Panorex is requested to leave our office there will be a $175 charge.

______________________________ ____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**

--MEDIA CONSENT--

We have a website and a Facebook page and would love to share your/your child's smile.

[ ] I do give Richards & Associates Orthodontics permission to share my photos.

[ ] I do not give Richards & Associates Orthodontics permission to share my photos.

______________________________ ____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**