Lucas Orthodontic Group

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(615) 377-7777

ADULT WELCOME FORM

HIPAA Privacy Review, Initial & Date _____

Today's date:					
PATIENT INFORMATION					
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
I prefer to be called:					Single / Mar / Div / Sep / Wid
Birth date: / /	Age:	Sex: ❑ M ❑ F	Email:		
Home address:	SSN:		Home #:		
City:	State:	ZIP:	Cell #:		
Occupation:	Employer:		Work #:		
How long there?	Where & when are the best times to reach you?				
Whom may we thank for referring you?					
Previous/Present Dentist:					
Other family members seen here:	**Person Responsible for Account:**				
SPOUSE INFORMATION					
His/Her Name:	Birth date: / /	SSN#:			
Employer:	Work #:				
Relative or friend not living with you:					
His/Her Name:	Relation:				
Home #:	Work #:				
ORTHODONTIC INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
PRIMARY INSURANCE:					
Orthodontic Coverage? ❑ Yes ❑ No	Dental Coverage? ❑ Yes ❑ No				
Insurance Company Name:	Insurance Company Phone #:				
Insurance Co. Address:	City:	State:	ZIP:		
Group #:	Insured Name:	Relation:	Insured DOB:		
Insured's ID #:	Insured's Employer:				
SECONDARY INSURANCE:					
Orthodontic Coverage? ❑ Yes ❑ No	Dental Coverage? ❑ Yes ❑ No				
Insurance Company Name:	Insurance Company Phone #:				
Insurance Co. Address:	City:	State:	ZIP:		
Group #:	Insured Name:	Relation:	Insured DOB:		
Insured's ID #:	Insured's Employer:				

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT, unless prior arrangements have been approved. 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. I authorize payment of my group insurance benefits to be made directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations, to my insurance company.

Signature: *Date:*

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:

Phone #:

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain:

Do you smoke or use tobacco of any kind? ❑ Yes ❑ No

Have you had any metal rods, pins or implants? ❑ Yes ❑ No

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No
Please list each one:

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. ❑ Yes ❑ No
If so, when?

For women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? Week #: ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems:

Y	N	Abnormal bleeding/Hemophilia	Y	N	High Blood Pressure
Y	N	AIDS	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for any reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack/Surgery	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Hepatitis	Y	N	Ulcers
Y	N	Herpes/Fever Blisters	Y	N	Venereal Disease

List any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/materials you are allergic to: _____

_____

OFFICE USE ONLY

I verbally reviewed the medical and dental information with this patient. Initials: _____ Date: _____

Doctor's Comments:

_____

_____

_____

DENTAL HISTORY

What are the main orthodontic concerns you would like to accomplish?

_____

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Have you ever had injury to your (circle one): Mouth Teeth Chin

Do you have any speech problems? ❑ Yes ❑ No

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: While Awake While Asleep

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

_____

I understand that the information 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 that 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. 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 Date

RELEASE OF MEDICAL INFORMATION

I authorize Lucas Orthodontic Group to release x-rays and photographs on file regarding my medical treatment to the person(s) listed below. I understand that by signing this release that the designated person(s) will be able to speak with any staff member of Lucas Orthodontic Group regarding my protected healthcare information.
Furthermore, I understand that Lucas Orthodontic Group cannot be held liable for any information the below stated person(s) may obtain regarding my medical care.
I understand that revocation of this authorization must be provided to Lucas Orthodontic Group in writing.

Lucas Orthodontic Group may release x-rays and photographs to the following specified person(s) other than myself:

- ☐ To my Dentist, _____
- ☐ To my Oral Surgeon, _____
- ☐ To my Periodontist, _____

_____

Signature Date

This office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.