DEFAY orthodontics

801-546-0892 | 95 S. Main St. | Kaysville UT 84037 | DEFAYORTHO.COM

Adult Patient Information

Patient's Name ____________________Preferred Name ____________ Sex: ___ M ___ F

Address ________________________City ___________State ______ Zip _______

Birth date _________Age ____ Patient is: ___ Single ___Married ___Separated ___Divorced ___Widowed

Home Phone (___) ___________ Cell (___) ____________ Best Phone Contact: ___Home ___Cell

E-Mail Address ____________________

Employed by ______________ Occupation ___________ Work Phone (___) _________

Name of closest relative ***not*** living with you ____________ Phone _______ Relationship ________

Names of *immediate* family members treated here ______________________________

If this is your first consult in our office, who referred you or how did you learn about us? ____________

Dentist ____________________ City _______________

What is your chief concern with your teeth? ______________________________

Patient's special interests, talents or hobbies ______________________________

Responsible Party Information

Name of Person responsible for Patient Account __________________Relationship:________

Address if *different* than patient ____________________ Cell (___) _____________

Employed by ___________________ Occupation ____________________

Orthodontic Insurance Information – If *No* Insurance check here ____

PRIMARY Insurance Information:

Name of Insured ______________________ Relationship to Patient _______________

Birth date of Insured _________ Social Security Number _____ - _____ - _____ or I.D. #_________

Employer ____________________ Business Address ______________________

Insurance Company __________________ Group # _________ Ins. Phone (___) _______

Insurance Address ____________________ City _________ State _____ Zip ________

Ortho Lifetime Maximum? $________ Used to date $______ Effective date _____Called to Confirm_____

SECONDARY Insurance Information:

Name of Insured ______________________ Relationship to Patient _______________

Birth date of Insured _________ Social Security Number _____ - _____ - _____ or I.D. #_________

Employer ____________________ Business Address ______________________

Insurance Company ________________ Group # ___________ Ins. Phone (___) _______

Insurance Address ____________________ City _________ State _____ Zip ________

Ortho Lifetime Maximum? $________ Used to date $______ Effective date _____ Called to Confirm_____

Health and Dental History

Patient's Medical Physician _______________________________ City _______________

Does/Has the Patient:

Yes	No	
___	___	Have any health problems? Explain ____________________
___	___	Take any medications? List ____________________
___	___	Have allergic reactions to medications? List ____________________
___	___	Currently seeing a physician, other than well checks? Explain ____________________
___	___	Received blood transfusions? Reason ____________________
___	___	Had tonsils and adenoids removed? When ____________________
___	___	Take medication for immunosuppressive disease? Explain ____________________
___	___	Have any Artificial Joints? Explain ____________________
___	___	Have Hay fever or Seasonal Allergies? Explain ____________________
___	___	Have Sinus problems? Explain ____________________

Has Patient ever had:

Yes	No		Yes	No		Yes	No	
___	___	Heart Murmur	___	___	Nervousness/Anxiety	___	___	Thumb/Finger Sucking
___	___	Rheumatic Fever	___	___	Emotional/Depression Problem	___	___	Mouth Breathing
___	___	Heart Surgery	___	___	Fainting/Dizziness	___	___	Nail Biting
___	___	High Blood Pressure	___	___	Epilepsy/Seizures	___	___	Speech Problems
___	___	Blood/Bleeding Disorder	___	___	Asthma	___	___	Teeth Grinding
___	___	Bone Disorder	___	___	Hives/Rash/Allergic Reaction	___	___	Teeth Clenching
___	___	Osteoporosis	___	___	Arthritis/Rheumatism	___	___	Jaw Popping
___	___	Paget's Disease	___	___	Cancer	___	___	Jaw Locking
___	___	Growth Disorder	___	___	Diabetes	___	___	Jaw Pain
___	___	Developmental Disorder	___	___	Kidney Disease	___	___	Frequent Headaches
___	___	Endocrine Disorder	___	___	Tuberculosis	___	___	Ringing in Ears
___	___	Attention Deficit/Hyperactivity	___	___	Pregnancy (Current/Recent)	___	___	Pain in Head/Neck

Other conditions, impairments or problems: ____________________

Frequency of dental checkups: Twice/yr ___ Once/yr ___ Infrequent ___ Never ___ Date of last visit__________

Yes	No	
___	___	Is there any unfinished care to be completed with your dentist? Explain: ____________________
___	___	Have you had any unpleasant dental experiences? Explain: ____________________
___	___	Are you frightened about orthodontic treatment? Explain: ____________________
___	___	Have you had any face or dental injuries? Explain: ____________________
___	___	Have you consulted with an orthodontist previously? With Whom? ____________________
___	___	Have you had any previous orthodontic treatment? When and With Whom? ____________________
___	___	Are you aware of missing or extra permanent teeth? Explain: ____________________
___	___	Are you satisfied with prior orthodontic treatment? Explain: ____________________

Is there any other information that may be helpful? ____________________

HIPAA PRIVACY POLICY: I understand that I have certain rights to privacy in regards to my protected health information. I have had the opportunity to receive, read, and understand this office's Notice of Privacy Policy.

INSURANCE: I authorize the release to my insurance company or companies any information, including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

Patient Signature Date