DR. RICK BALLARD
Orthodontist

PATIENT INFORMATION FOR ADULTS

Please complete this form front and back

Patient Information

Todays Date: ____/____/____

Patients Name:_____ Preferred Name:_____ ☐ Male ☐ Female Birthdate____/____/____

Address:_____ City:_____ State:_____ Zip:_____ How long at address: _____

Cell Phone:_____ Email Address: _____ SS# _____-____-_____

Occupation:_____ Employer:_____ How Long:_____ Work Phone #:_____

Have we seen any other family members? ☐ Yes ☐ No If yes who? _____

How did you hear about our practice? _____

Reason for orthodontic consultation:_____

Who noticed an orthodontic problem ☐ Patient ☐ Dentist ☐ Other _____

What concerns you most about orthodontic treatment? ☐ Appearance ☐ Cost ☐ Time ☐ Discomfort ☐ Results

Have you had any previous orthodontic treatment? ☐ Yes ☐ No Please describe: _____

Family Information

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name (if applicable):_____ Birthdate____/____/_____ SS# _____-____-_____

Email Address: _____

Home Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Occupation:_____ Employer:_____ How Long:_____ Work Phone #:_____

Responsible party name (if different than above): _____ Birthdate____/____/_____ SS# _____-____-_____

Email Address: _____

Home Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Occupation:_____ Employer:_____ How Long:_____ Work Phone #:_____

In case of emergency please contact: _____ Phone #:_____

Dental Insurance

Do you have dental insurance? ☐ Yes ☐ No

Does this policy have orthodontic coverage? ☐ Yes ☐ No ☐ Don't Know

Primary insurance: Name of Insurance Carrier:_____ Employer:_____

Carrier Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Primary Insured Full Name:_____ Primary Birthdate____/____/_____

Relationship to patient:_____ Member ID#: _____ Group #: _____

Secondary insurance: Name of Insurance Carrier:_____ Employer:_____

Carrier Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____

Primary Insured Full Name:_____ Primary Birthdate____/____/_____

Relationship to patient:_____ Member ID#: _____ Group #:_____

Dental History

Dentist's Name:_____ City:_____ Phone #:_____ Last Visit: ____/____/____

Did they refer you to our office? ☐ Yes ☐ No Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ As needed ☐ Never

Please check if there is a history of:

☐ Clenching/grinding ☐ Jaw joint pain (TMJ) ☐ Tension headaches ☐ Bleeding gums

☐ Tongue thrust ☐ Jaw clicking/popping ☐ Mouth breathing ☐ Lip/tongue biting

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Do you see any dental specialists? ☐ Yes ☐ No Who? _____

Do you have anxiety about dental treatment? ☐ Yes ☐ No Explain: _____

Dental History Continued...

Have you had any facial or dental injuries? ☐ Yes ☐ No Explain: _____

Is any part of your mouth sensitive to temperature? ☐ Yes ☐ No Where: _____

Is any part of your mouth sensitive to pressure? ☐ Yes ☐ No Where: _____

Have you noticed any recent changes in your bite? ☐ Yes ☐ No Explain: _____

Please list any other dental information that may be helpful: _____

_____

Medical History

Physician's Name:_____ City:_____ Phone #:_____ Last Visit: ____/____/____

Are you currently under physician's care? ☐ Yes ☐ No Explain: _____

For Women:

Is there any chance you could be pregnant? ☐ Yes ☐ No Are you currently nursing? ☐ Yes ☐ No

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Please list **ANY & ALL** known allergies you are aware of (ex: latex, metals, foods, plastics, drugs/medications)_____

_____

Please list **ANY & ALL** medications or vitamins you are currently taking: _____

_____

Are you currently, or have you previously taken any medications known as Bisphosphonates or bone density medications? (ex: Aclast, Actonel, Actonel+Ca, Aredia Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

☐ Yes ☐ No When?: _____

Please check if there is a history of:

☐ Abnormal Bleeding	☐ Blood transfusion	☐ Epilepsy	☐ Herpes/fever blisters	☐ Rheumatic/scarlet fever
☐ ADD/ADHD	☐ Bone disorder	☐ Fainting	☐ High blood pressure	☐ Shingles
☐ Aids/HIV Positive	☐ Cancer/Chemo/radiation	☐ Glaucoma	☐ Low blood pressure	☐ Sleep/Airway disorder
☐ Anemia	☐ Chemical dependency	☐ Handicap/disability	☐ Lupus	☐ Stomach ulcers
☐ Anxiety/Depression	☐ Circulatory problems	☐ Headaches (frequent)	☐ Mitral Valve Prolapse	☐ Stroke
☐ Arthritis	☐ Cortisone treatment	☐ Heart problems	☐ Nervous system problem	☐ Thyroid problems
☐ Artificial joints	☐ Cough (persistent)	☐ Heart Murmur	☐ Pacemaker	☐ Tobacco habit
☐ Asthma	☐ Diabetes	☐ Hemophilia	☐ Psychiatric Care	☐ Tonsils/adenoids removed
☐ Autism	☐ Emphysema	☐ Hepatitis	☐ Respiratory disease	☐ Tuberculosis

Please use this space explain any above answers or list any additional health information we should know about:_____

_____

_____

Have you had any surgeries or hospital stays? ☐ Yes ☐ No Explain: _____

_____

Financial and Treatment Authorization

I affirm that the information I have given is accurate and complete to the best of my knowledge. It is my responsibility to inform this office of any changes in my personal information or health status. I will not hold this office, our doctors or staff responsible for any errors or omissions I have made in the completion of this form. **Signature:** _____ **Date:** ____/___/____

This office accepts insurance, I assign directly to Dr. Ballard all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. **Signature:** _____ **Date:** ____/___/____

This office reserves the right to verify the credit status of potential patients and/or responsible party of the patients prior to extending credit for treatment fees and may use the services of one or more credit reporting agencies. **Signature:** _____ **Date:** ____/___/____

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