Date:________________

Adult Welcome Information

Name____ Nickname ____________________
Last First Middle

Address____
Street City State Zip

Home Phone___________________ Cell Phone____________________ Email_________________________________

Date of Birth ___________________ SSN _________________________________ Dentist ______________________

Whom may we thank for referring you to our office? (Check all that apply):

- ☐ Dentist_________________________________
- ☐ Friend/Family/Neighbor___________________
- ☐ Internet (Where specifically?)_____________
- ☐ Other_________________________________
- ☐ Mansfield Cares
- ☐ Miles for Meredith
- ☐ School Field Trip
- ☐ Mansfield ISD Education Foundation
- ☐ Feed the Kids
- ☐ Location

What are your main concerns that you would like orthodontics to accomplish?___________________________________

Dental Status

When were you last seen by the dentist? ____

☐Yes ☐No Have you had previous orthodontic treatment or consultation? When? Why? __________________
☐Yes ☐No Has any member of the family had orthodontic treatment? ________________________________
☐Yes ☐No Have you had any trouble associated with dental treatment? _______________________________
☐Yes ☐No Have you had any teeth extracted? Why? ____
☐Yes ☐No Have you ever injured or broken any teeth? When and what happened? ____________________
☐Yes ☐No Have you ever injured the head or face? When and what happened? ________________________
☐Yes ☐No Do you have any missing or extra teeth? ____
☐Yes ☐No Do you have any problem with eating, chewing, or swallowing? ___________________________
☐Yes ☐No Do you suck your thumb, fingers or tongue? (circle which) _____________________________
☐Yes ☐No Do you have any dental or facial pain? ____
☐Yes ☐No Does your jaw joint make noises or hurt when opening, closing, or chewing? _________________
☐Yes ☐No Do you habitually grind or clench the teeth together? __________________________________
☐Yes ☐No Do you normally breathe with the lips parted? ____
☐Yes ☐No Are you aware of any swellings or growths in the mouth or face? ___________________________
☐Yes ☐No Do you have negative or resistant feelings about orthodontic treatment? ____________________
☐Yes ☐No Are you especially concerned about orthodontic treatment? ______________________________
☐Yes ☐No Are you dissatisfied with the appearance of the teeth? _________________________________
☐Yes ☐No Are you especially resistant to: ☐ Braces ☐ Headgear ☐ Retainers
☐Yes ☐No Is there any other information we should know? ______________________________________

Medical History

Please list any:
Serious illness or condition ____
Allergies or known drug sensitivity ____
Current medical care ____
Current medications ____

Tonsils and Adenoids: ☐ Present ☐ Removed at age __________

☐Yes ☐No Do you have frequent colds or ear infections?

Have you ever been diagnosed or treated for the following (Check all that apply.):

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Endocrine Disorders
- ☐ Bone Disorder
- ☐ Emotional Problems
- ☐ Multiple Sclerosis
- ☐ Asthma
- ☐ Epilepsy
- ☐ Herpes
- ☐ Hepatitis
- ☐ Low Blood Pressure
- ☐ Tuberculosis
- ☐ Bleeding Disorder
- ☐ Cerebral Palsy
- ☐ Cancer
- ☐ AIDS or HIV+
- ☐ Arthritis
- ☐ Diabetes

Responsible Party Information

Name____
Last First Middle

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address_________ Rent or Own?______________

Previous Address (if less than 3 yrs.) ____
Street City State Zip

SSN ______________________ Date of Birth ______________________ Marital Status ______________________

Home Phone________________ Work Phone________________ Cell Phone ________________ E-mail ________________________

Employer __________________________ Occupation ___________________ No. Years Employed __________________

Employer's Address ____
Street City State Zip

Spouse's Name____ Relationship to Patient _____________________
Last First Middle

SSN ______________________ Date of Birth ______________________

Work Phone________________ Cell Phone ________________ E-mail ________________________

Employer __________________________ Occupation ___________________ No. Years Employed __________________

Employer's Address ____
Street City State Zip

A B C

Insurance Information

Insured's Name____ Relationship to Patient _______________________
Last First Middle

Insured's Mailing Address ____
Street City State Zip

Insured's SSN ___________________ Insured's Date of Birth _________________ Home Phone ________________ Work Phone _______________

Insurance Company _____________________________Group No. _______________ Local No. _______________ Employer __________________

Insurance Co. Address____
Street City State Zip

Insurance Co. Phone___________________________

Do you have dual coverage? ☐Yes ☐No If yes:

Insured's Name____ Relationship to Patient _______________________
Last First Middle

Insured's Mailing Address ____
Street City State Zip

Insured's SSN ___________________ Insured's Date of Birth _________________ Home Phone ________________ Work Phone _______________

Insurance Company _____________________________Group No. _______________ Local No. _______________ Employer _________________

Insurance Co. Address ____
Street City State Zip

Insurance Co. Phone___________________________

Signature of Patient

To the best of my knowledge, the information given is correct. Furthermore, I understand that it is my responsibility to inform this office of any changes in my medical status or insurance information. I authorize Dr. Herrmann to perform a complete orthodontic evaluation including digital photos and 3D digital x-rays. I also understand that diagnostic records and name may be used in educational and promotional purposes. I also understand that in order to receive complete information on financial options, credit bureau reports may be obtained.

Signature: ____________________________________ Date: _______________________