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: _____

About iCat® CBCT Cone Beam Scans

Rick Herrmann Orthodontics offers an exciting technology for our patients. This technology is iCat® Cone Beam Computer Computed Tomography (CBCT) imaging, sometimes called 3-D radiographs or x-rays. Using CBCT means we have the ability to take 3D images of the teeth, jaws, bones and facial structures at lower costs and with less energy than a typical CT scan used in hospitals. 3D imaging provides us the opportunity of improved diagnosis for our patients, especially in cases of impacted teeth, dental implants, surgical treatment, as well as more complex cases. Understandably you may have questions about exposure to these types of x-rays. Here are some facts you should know about 3-D imaging. An **iCat® CBCT (@8.5 seconds) exposure is;**

- About ½ as much as a full series of digital dental images
- About 1/5 as much as a full (28) mouth series of standard dental x-rays
- About 1/70 as much as a typical medical CT scan.

CBCT therefore offers our patients enhanced diagnostic value at significantly reduced exposure. At the same time, CBCT scans can image the entire head and most of the neck. As dentists and orthodontists, we evaluate teeth, jaws and surround supporting bone using CBCTs for those limited purposes. Our training and dental license does not provide for evaluating and diagnosing outside those areas. However since CBCT imaging can cover a broader area, we want to offer you the opportunity to have your CBCT scan read by an oral radiologist, trained and licensed to evaluate and diagnose a broader area. CBCT may show evidence of disease of the cervical spine, skull or arteries. We can refer you to a radiology group for this purpose.

( ) Yes, I want to have the iCat® CBCT scan(s) read by an oral radiologist and understand that there is an **additional fee of $250.00 that must be paid prior to having each scan sent out to be read.**

( ) No, I understand the risks and benefits of having CBCT scan(s) read and interpreted by an oral radiologist, however I knowingly decline such a referral.

_____ _____

Signature of responsible party Date

1821 Cannon Drive ♦ Mansfield, Texas 76063 ♦ 817.473.9880
www.HerrmannOrthodontics.com

RICK HERRMANN ORTHODONTICS, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Patient's Name

_____

Signature of Patient or Parent/Guardian

_____

Relationship to Patient, If **Not** the Patient

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual or Parent/Guardian refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)