

# Lucas Orthodontic Group

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 Belle Meade • Brentwood • Columbia • Cool Springs • Gallatin • Nolensville  
 (615) 377-7777

ADULT WELCOME FORM

HIPAA Privacy Review, Initial & Date

Today's date:						
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid
I prefer to be called:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	
Birth date:	/	/	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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:			Last Visit Date:			
Other family members seen here:			<b>Person Responsible for Account:</b>			
<b>SPOUSE INFORMATION</b>						
His/Her Name:		Birth date:		/	/	SSN#:
Employer:			Work #:			
Relative or friend not living with you:						
His/Her Name:			Relation:			
Home #:			Work #:			
<b>ORTHODONTIC INSURANCE INFORMATION</b>						
(Please give your insurance card to the receptionist.)						
<b>PRIMARY INSURANCE:</b>						
Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<b>SECONDARY INSURANCE:</b>						
Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<p>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.</p>						
Signature:			Date:			
Update 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 \_\_\_\_\_