University Centre
DENTAL ASSOCIATES

Adult
Orthodontics

301.220.1900

The benefits of a happy, healthy smile are immensurable. Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

About You

Today's Date: _____ ❑ Male ❑ Female

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

❑ Single ❑ Married ❑ Divorced ❑ Widow ❑ Separated

Name: _____
Last *First* *MI*

I prefer to be called: _____

Birthdate: ____/ ____/ ____ Age: _____

SS# _____

Home Address: _____
Apt #

_____
City *State* *Zip*

Home Phone: ( ) _____

Cell Phone: ( ) _____

Work Phone: ( ) _____

_____
Extension *Direct Line*

Occupation: _____

Employer/School: _____

Employer/School Address: _____

_____
City *State* *Zip*

How long have you worked/been a student there? _____

Where/when are best times to reach you? _____

Other family members seen by us: _____

Who referred you? _____

General Dentist: _____

Person Responsible for Account: _____

Spouse Information

Name: _____

Employer: _____ SS#: _____

Work Phone: ( ) _____
Ext #

Birthdate: ____/ ____/ ____ DL#: _____

Relative or Friend not living with you.

Name: _____ Relation: _____

Work #: _____ Home # _____

Orthodontic Insurance

Primary Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Dental Coverage? ❑ Yes ❑ No

Insurance Company: _____

Address: _____

_____
City *State* *Zip*

Insurance Phone: ( ) _____

Group # *(Plan, Local, or Policy#)*: _____

Insured's Name: _____

Birthdate: ____/ ____/ ____ Insured's ID#: _____

Insured's Employer: _____

Employer Address: _____

_____
City *State* *Zip*

Secondary Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Dental Coverage? ❑ Yes ❑ No

Insurance Company: _____

Address: _____

_____
City *State* *Zip*

Insurance Phone: ( ) _____

Group # *(Plan, Local, or Policy#)*: _____

Insured's Name: _____

Birthdate: ____/ ____/ ____ Insured's ID#: _____

Insured's Employer: _____

Employer Address: _____

_____
City *State* *Zip*

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, 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 herby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I herby release of any information, including diagnosis and records of treatment or examination rendered to my insurance company.

_____
Signature *Date*

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone Number: ( ) _____

Date of last visit: _____/ _____/ _____

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 in any form? ❑ 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: _____

_____

Have you ever taken Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin)

For Women

Are you currently taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week#: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems:

Y N	Abdominal Bleeding/ Hemophilia	Y N	Hepatitis/Jaundice
Y N	AIDS or HIV Infection	Y N	Herpes/Fever Blisters
Y N	Alcohol/Drug Abuse	Y N	High Blood Pressure
Y N	Anemia	Y N	Hospitalized for Any Reason
Y N	Angina	Y N	Kidney Problems/Disease
Y N	Arthritis	Y N	Liver Disease
Y N	Artificial Bones/Joints/Valves	Y N	Low Blood Pressure
Y N	Asthma	Y N	Leukemia
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer/Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Chest Pains	Y N	Pacemaker
Y N	Colitis	Y N	Psychiatric Problems
Y N	Congenital Heart Defect	Y N	Radiation Treatment
Y N	Diabetes	Y N	Recent Weight Loss
Y N	Difficulty Breathing	Y N	Respiratory Problems
Y N	Emphysema/Easily Winded	Y N	Rheumatic/Scarlet Fever
Y N	Epilepsy/Convulsions	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sickle Cell Disease/Traits
Y N	Frequently Tired	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever/Allergies	Y N	Swollen Ankles
Y N	Heart Attack/Surgery	Y N	Thyroid Problems
Y N	Heart Disease	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers/Stomach Troubles
		Y N	Venereal Disease

Are you allergic to any of the following:

Y N	Aspirin	Y N	Jewelry/Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Barbiturates
Y N	Local Anesthetics	Y N	Penicillin	Y N	Sedatives
Y N	Erythromycin	Y N	Tetracycline	Y N	Iodine
		Y N	Antibiotics		

Please list any other drugs/medications that you are allergic to: _____

_____

Dental History

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

_____

_____

Have you ever been evaluated for or received 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/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you still have wisdom teeth? ❑ Yes ❑ No

Have you ever had an injury to your:
❑ Mouth ❑ Teeth ❑ Chin

Do you have any speech problems? ❑ Yes ❑ No
Is so please explain: _____

Do you generally breathe through your mouth? ❑ Yes ❑ No
If yes, this happens: ❑ While Awake ❑ While Asleep

Do you have any missing/extra permanent teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

_____

I understand that the information that 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*

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

Office Use Only

I have verbally reviewed the medical/dental information with th patient named herein.

Initials: _____ Date:_____

Doctor's Comments _____

_____

_____

_____

_____

_____

_____

7833 Walker Drive • Suite 10 • Greenbelt Maryland 20770 • Fax: 301.474.0433