David W. Johnson, D.D.S.

Alameda Orthodontics
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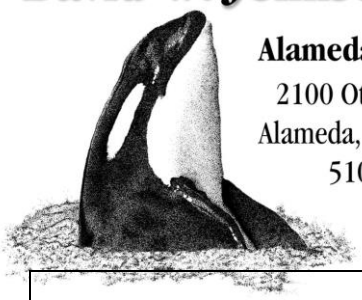

ADULT

PATIENT INFORMATION – ADULT

Your Name _____ Age _____ Date of Birth_____
Address _____ Main phone _____
City, ST Zip _____ Email _____
General Dentist's Name _____ and Telephone_____
How did you hear about our office?_____
What is your main concern regarding the your teeth and jaws?_____
_____

MEDICAL HISTORY

Yes ☐ No ☐ Have the tonsils and/or adenoids been removed? If so, at what age? _____
Yes ☐ No ☐ Frequent colds or ear infections? Please describe _____
Yes ☐ No ☐ History of major illness? Please describe _____
Yes ☐ No ☐ Any drug sensitivities? Please describe _____
Yes ☐ No ☐ Taking any medication now? Please list _____
Yes ☐ No ☐ Under medical care now? Please describe _____
Yes ☐ No ☐ Have you been vaccinated and tested for immunity to Hepatitis B (HBV)? Date_____

Check any of the following for which you have been treated:

☐ Diabetes	☐ Asthma	☐ Prolonged bleeding
☐ Arthritis	☐ Epilepsy	☐ Nervous disorders
☐ Tonsillitis	☐ Hepatitis	☐ Rheumatic fever
☐ Brain injury	☐ Tuberculosis	☐ Heart condition
☐ Cancer	☐ AIDS or HIV	☐ Other _____

☐ **None of the above**

DENTAL HISTORY

Yes ☐ No ☐ Have there been any severe injuries to the face? Please describe _____
Yes ☐ No ☐ Are you aware of any missing permanent teeth? Which ones? _____
Yes ☐ No ☐ Do you clinch or grind your teeth? Please describe when _____
Yes ☐ No ☐ Do you have pain or clicking upon opening or closing your mouth or jaws? _____
Yes ☐ No ☐ Have you had any previous orthodontic treatment? When and where? _____
When did you last visit the dentist? _____

Comments _____
_____

PLEASE COMPLETE THE NEXT PAGE ALSO

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status_____
Residence _____
Mailing Address if different _____
Main phone _____ Work Phone _____
Birthdate _____ Relationship to patient _____
Employer_____ Employer Address_____
Spouse/Partner name _____ Relationship to patient_____
Employer _____ Employer Address_____
Birthdate _____ Main Phone_____ Work phone _____
Parent's home address and phone if not living with patient_____

DENTAL INSURANCE INFORMATION

To assist us in determining your financial arrangements, and because your insurance is a contract between you and your insurance company, please call your insurance carrier or benefits officer to verify this information <u>BEFORE</u> your appointment.

Insured's name _____Insured's Soc Sec or ID#_____Group/Local No. _____
Insurance Company _____ Insurance Co. Address _____
Insurance Co. Phone _____ Insured's relationship to patient _____
Ortho Benefits □ No □ Yes %_____ Lifetime Maximum Amount_____Eligible now □ Yes □ No
Effective Date _____Are orthodontic records covered under general dental? □ Yes □ No
Does insurance carrier require additional claim forms after the initial claim form? □ Yes □ No
If yes, how often?_____
Do you have dual coverage? □ Yes □ No If yes, please complete the above information for the second insurance carrier on a separate piece of paper or below.

The above information is accurate to the best of my ability.

Signature _____ Date _____