Larry A. Rose DDS, MS, Inc.

SPECIALIST IN ORTHODONTICS

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Welcome to Our Practice!

Patient Information Form | For Adults

About You

PATIENT INFORMATION

Today's Date:___________________________
Best e-mail contact:____
First Name: ____________________________ Middle Initial:____________ Last Name: ____
I prefer to be called: ____ DOB: _____________________Age:____________________
Home #:_________________________ Work #:________________________ Ext#: ______ Cell #:__________________________________
Home Address: ____ apt./unit/ste.: _________________________
City:_________________________________ State: _______ Zip:____________
Other family members seen by us: ____

RESPONSIBLE PARTY (If someone other than the patient)

First Name: ____________________________ Middle Initial:____________ Last Name:____
Billing Address:____ City: ________________ State: _____ Zip: _____________
Home #:_________________________ Work #:________________________ Ext #: ______ Cell #:__________________________________
Employer: ____

EMERGENCY CONTACT

Name: ____ Relation: ____
Home #:_________________________ Work #:________________________ Ext #: ______ Cell #:__________________________________

SPOUSE INFORMATION

Name: ________________________________ Employer:____
Home #:_________________________ Work #:________________________ Ext #: ______ Cell #:__________________________________

About Your Employer

Name: ________________________________Address: ____
Occupation: ___________________________ How long have you worked there:____

Dental Information

Previous/Present Dentist:______________________________ Last Visit: _______________________ Phone #:___________________
Street Address: ____ City: ________________ State: ______ Zip: ___________

Insurance Information

PRIMARY DENTAL INSURANCE

Ins. Name: ____
Claims Address: _____________________________________
Insurance Co. Phone #: _______________________________
Group #: ____
Policy #:____
Insured's Name: _____________________________________
Relationship to Patient: ______________________________
Insured DOB:____
Insured's Employer: __________________________________
SS #: ____
Orthodontic Coverage: ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Ins. Name: ____
Claims Address: _____________________________________
Insurance Co. Phone #: _______________________________
Group #: ____
Policy #:____
Insured's Name: _____________________________________
Relationship to Patient: ______________________________
Insured DOB:____
Insured's Employer: __________________________________
SS#: ____
Orthodontic Coverage: ☐ Yes ☐ No

OVER

Dental History

Why have you come to the orthodontist today? ___________
____
Are you currently in pain? ☐ Yes ☐ No
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Do you like your smile? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
How many times a week do you floss? ______________
How many times a day do you brush?______________
Types of bristles: ☐ Hard ☐ Medium ☐ Soft
Please list all allergies to drugs or other materials:
☐ Latex ☐ Penicillin ☐ Other:____________________

Medical History

Do you have a personal physician? ☐ Yes ☐ No
Physician's name: ____________________________
Phone: ______________ Last visit: _____________
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under doctor's care? ☐ Yes ☐ No
Please explain: ______________________________
Are you taking any prescription drugs? ☐ Yes ☐ No
Please list: _________________________________
____
WOMEN ONLY: Are you taking birth control? ☐ Yes ☐ No
Which one? __________________________________
Are you preganant? __________ week # ___________
Are you nursing?__________________

Have you ever had any of the following medical problems?

☐Y ☐N Prosthesis
☐Y ☐N Heart Attack
☐Y ☐N Cancer
☐Y ☐N Diabetes
☐Y ☐N Rheum. Fever
☐Y ☐N HIV+/AIDS
☐Y ☐N Hemophilia
☐Y ☐N Asthma
☐Y ☐N Hepatitis (A, B, C?)
☐Y ☐N Tuberculosis
☐Y ☐N Shingles
☐Y ☐N Fever Blister
☐Y ☐N Veneral Dis.
☐Y ☐N Ulcers/Colitis
☐Y ☐N Heart Murm.
☐Y ☐N History of Scarlet Fever
☐Y ☐N Congenital Heart Def.
☐Y ☐N Convulsions/Epilepsy
☐Y ☐N Abnormal Bleeding
☐Y ☐N Artificial Valves
☐Y ☐N Heart Surgery/Pacemkr.
☐Y ☐N Any Stays in Hospital
☐Y ☐N Kidney/Liver Problems
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Artificial Bones/Joints
☐Y ☐N Sev./Freq. Headaches
☐Y ☐N Hi/Lo Blood Pressure
☐Y ☐N Drug/Alcohol Abuse
☐Y ☐N Blood Transfusions
☐Y ☐N Anemia/Radiation Tmt.
☐Y ☐N Other: ____________
____

Are you allergic to any of the following?

☐Y ☐N Aspirin
☐Y ☐N Codeine
☐Y ☐N Latex
☐Y ☐N Penicillin
☐Y ☐N Erythromycin
☐Y ☐N Tetracycline
☐Y ☐N Dental Anesthetics
☐Y ☐N Other: ____________

____
DOCTOR CHECKED MEDICAL HISTORY

Are there any health issues related to your oral care not fully addressed by the above questionnaire that you would like to discuss with the orthodontist? ☐Yes ☐No

I hereby give full permission and release from liability to Dr. Larry A. Rose and any other orthodontic associates who may be part of my treatment,Larry A. Rose, DDS, MS, Inc., and Houston Area Orthodontics concerning the display of photograph(s) of myself on the office bulletin board, on website(s), Face Book pages(s) associated with Dr. Larry A. Rose, Larry A. Rose, DDS, MS, Inc., Houston Area Orthodontics, or any other website(s) that may refer to Dr. Larry A. Rose. I understand that my first name may be used to identify the photograph, and reference may be made to treatment status (for example, starting treatment or having braces removed, etc.)

I understand the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment. I authorize the insurance company indicated on this form to pay to Larry A. Rose, DDS, MS, Inc. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Larry A. Rose, DDS, MS, Inc. to release all necessary information to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

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

Printed name of person signing:______________________ Signature:______________________ Date:__________

TO BE FILLED OUT BY THE ORTHODONTIST

LOWER ARCH: ________________________________
UPPER ARCH: ________________________________
CLASS:__________________ MIDLINE:__________________
OVERJET:_________________ OVERBITE:_________________
COMMENTS: __________________________________
____
____

Optional Appliance ☐ YES ☐ NO