MINGA ORTHODONTICS

Date _____

1 Patient Information

Name _____ ☐ M ☐ F

Birthdate ____ / ____ / ____ Age _____ SS # _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

E-mail address _____

Home Phone (____) _____ Cell Phone (____) _____

Home Address _____
STREET APT #

_____
CITY STATE ZIP

Employer _____

Employer's Address _____
STREET APT #

_____
CITY STATE ZIP

Occupation _____ Years Employed ____

Work Phone (____) _____ Direct Line (____) _____

When are the best times to reach you? _____

General Dentist _____

☐ Present ☐ Previous Date of last visit ____ / ____ / ____

2 Spousal Information

Spouse's Name _____ ☐ M ☐ F

Birthdate ____ / ____ / ____ Age _____ SS # _____

Employer _____ Work Phone (____) _____

3 Person Responsible for Account

Name _____ SS # _____

Relation to Patient _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____

Billing Address _____
STREET APT #

_____
CITY STATE ZIP

4 Emergency Contact Information

In the event of an emergency, whom should we contact?

Name _____

Relation to Patient _____

Home Phone (____) _____ Work Phone (____) _____

5 Patient Orthodontic Insurance

PRIMARY INSURANCE

Orthodontic Coverage ☐ Y ☐ N Dental Coverage ☐ Y ☐ N

Insurance Co. Name _____

Insurance Co. Address _____
STREET SUITE #

_____
CITY STATE ZIP

Insurance Co. Phone (____) _____

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

Policy Owner's Name _____

Policy Owner's Relation to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ ID # _____

Policy Owner's Employer _____

Employer Address _____
STREET SUITE #

_____
CITY STATE ZIP

SECONDARY INSURANCE

Orthodontic Coverage ☐ Y ☐ N Dental Coverage ☐ Y ☐ N

Insurance Co. Name _____

Insurance Co. Address _____
STREET SUITE #

_____
CITY STATE ZIP

Insurance Co. Phone (____) _____

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

Policy Owner's Name _____

Policy Owner's Relation to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ ID # _____

Policy Owner's Employer _____

Employer Address _____
STREET APT #

_____
CITY STATE ZIP

Form is continued on back

7 Patient Medical History

Current Personal Physician Name _____ ☐ N/A

Phone (_____) _____ Date of last visit _____ / _____ / _____

Your Current Physical Health ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

If yes, please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

If yes, please list each one: _____

FEMALE PATIENTS:

Are you using a prescribed method of birth control? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week Number _____

Are you nursing? ☐ Y ☐ N

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

Y	N	Abnormal Bleeding	Y	N	Heart Surgery / Pacemaker
Y	N	Anemia	Y	N	Hemophilia
Y	N	Artificial Bones / Joints / Valves	Y	N	Hepatitis
Y	N	Arthritis	Y	N	High / Low Blood Pressure
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Blood Transfusion	Y	N	Hospitalization for any reason
Y	N	Cancer / Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Shingles
Y	N	Epilepsy / Seizures / Fainting	Y	N	Sickle Cell Disease / Traits
Y	N	Fever Blisters / Herpes	Y	N	Sinus Problems
Y	N	Frequent / Severe Headaches	Y	N	Stroke
Y	N	Glaucoma	Y	N	Tuberculosis (TB)
Y	N	Heart Attack	Y	N	Ulcers / Colitis
Y	N	Heart Murmur	Y	N	Venereal Disease

Please list any serious medical condition(s) you have ever had _____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Codein	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Metals / Plastics	Y	N	Latex	Y	N	Other

Please list any other drug / material allergies: _____

_____

8 Patient Dental History

What would you like orthodontics to accomplish? _____

_____

Have you had / been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in the jaw (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N

Do your gums bleed? ☐ Y ☐ N

Have you ever had injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Indicate any speech problems _____

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Have you ever taken Fosamax or any other biophosphonate? ☐ Y ☐ N

Have you ever taken Phen-Fen? ☐ Y ☐ N

Do you smoke or use tobacco in any form? ☐ Y ☐ N

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 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.

SIGNATURE _____ DATE _____

This office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit treatment frees and may, at the discretion of the office, use the services of one or more credit reporting services.

SIGNATURE _____ DATE _____

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 insurances does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

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.

Thank you for filling out this form!