BICKLER ORTHODONTICS

Orthodontic Treatment for Adults & Adolescents

Adult Orthodontic Acquaintance Card

(please print)

Patient's Name _____ Date _____

Nickname _____ Sex _____ Age _____ Birthdate _____

Address _____ Yrs at Address _____

City _____ ZIP _____ Phone _____

Occupation _____ No. yrs. _____

Employed by _____ # of years _____ Work Phone _____

Soc. Sec. No. _____ ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

Spouse's Name _____ DOB _____

E-mail _____ Prefered Contact Method? ❑ Phone ❑ Text ❑ Email

Patient's Dentist _____

Why did you seek this orthodontic consultation? _____

Who Referred You? _____

Have you ever been examined by an orthodontist before?	❑ YES	❑ NO	
Is the patient interested in having orthodontic treatment?	❑ YES	❑ NO	
Has any other family member had orthodontic treatment?	❑ YES	❑ NO	
Relatives or friends treated here?	❑ YES	❑ NO	Who? _____
Does your insurance cover orthodontics?	❑ YES	❑ NO	

DENTAL INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. For your convenience, we will gladly submit insurance claims pertaining to any any charge for care in our office.

Policy holder's name _____ Soc. Sec. No. _____

LAST FIRST MIDDLE

Policy holder's Date of Birth _____

Insurance Co. _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? ❑ YES ❑ NO if yes:

Policy holder's name _____ Soc. Sec. No. _____

Insurance Co. _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

MEDICAL HISTORY

Physician: _____

Is the patient in good health? YES ❑ NO ❑

Has the patient seen a physician in the last 2 years?

YES ❑ NO ❑

What was the reason for the visit? _____

_____

List any drugs or medications now being taken?

_____

List any allergies or sensitivity? _____

_____

Does the patient wear contact lenses? YES ❑ NO ❑

Are you currently taking biophsphates? YES ❑ NO ❑

Check any of the following for which the patient has been treated:

Diabetes	**YES ❑**	**NO ❑**
Hepatitis	**YES ❑**	**NO ❑**
Heart Trouble	**YES ❑**	**NO ❑**
Glaucoma	**YES ❑**	**NO ❑**
Rheumatic Fever	**YES ❑**	**NO ❑**
High Blood Pressure	**YES ❑**	**NO ❑**
Bone Disorders	**YES ❑**	**NO ❑**
Prolonged Bleeding	**YES ❑**	**NO ❑**
Thyroid Disorders	**YES ❑**	**NO ❑**
Fainting/Dizziness	**YES ❑**	**NO ❑**
Tuberculosis	**YES ❑**	**NO ❑**
Epilepsy	**YES ❑**	**NO ❑**
Anemia	**YES ❑**	**NO ❑**
Asthma	**YES ❑**	**NO ❑**
Arthritis	**YES ❑**	**NO ❑**
Head & Neck Pain	**YES ❑**	**NO ❑**
Immunity Disorders	**YES ❑**	**NO ❑**
AIDS	**YES ❑**	**NO ❑**

DENTAL HISTORY

Dentist: _____

Date of the last dental exam: _____

Has the patient been told of:

Unfinished Dental Care	YES ❑	NO ❑
Thumb/finger sucking	YES ❑	NO ❑
Tongue thrusting	YES ❑	NO ❑
Mouth breathing	YES ❑	NO ❑
Teeth grinding/clenching	YES ❑	NO ❑
Missing or extra permanent teeth	YES ❑	NO ❑
Ear infections	YES ❑	NO ❑
Gum Disease	YES ❑	NO ❑
Fear of treatment	YES ❑	NO ❑

Have you ever been injured by a fall or blow?

YES ❑ NO ❑

Have tonsils and adenoids been removed?

YES ❑ NO ❑

Have any primary or permanent teeth been extracted?

YES ❑ NO ❑

Comments: _____

_____

_____

_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Phone _____ Relationship _____

AUTHORIZATION RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Reviewed by: _____

Signature Date