



Darcie R. Bradley, DMD, MS

Specialist in Orthodontics for
Children and Adults

Adult Patient Information

Please write in print.

With whom may we thank for referring you to our office? _____

Have we treated any family or friends? _____

Patient Information

Name: _____ Gender: _____

Birthdate: _____ Age: _____ SS#: _____

Are you: Single Married Divorced Separated Widowed

Home phone: Cell: Work:

Address: _____ City: _____ State: _____ ZIP: _____

How long have you lived at this address? _____

Employer: _____

Employer's address: _____ City: _____ State: _____ ZIP: _____

Occupation: _____ How long? _____

Medical History

Primary care physician: _____ Date of last visit: _____

Please list *all* currently taken medication: _____

Known allergies: _____

Current medical treatment or past hospitalizations: _____

Females only. When was her first menstrual cycle? _____

Is the patient pregnant? Yes No Taking birth control? Yes No

Does patient have a history with *any* of the following?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleeping disturbances |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Other _____ | | | |

If you checked *any* of the above, please explain. _____

Does the patient have other medical condition(s) we should be aware of? _____

Dental History

Patient's dentist: _____ How long/often? _____

Does patient have a history with *any* of the following?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Previous orthodontic treatment | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Speech impediment | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Mouth/facial injuries | <input type="checkbox"/> Periodontal care | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Chin scar |
| <input type="checkbox"/> Thumb/finger sucking | <input type="checkbox"/> Mouth breather | <input type="checkbox"/> Snoring while asleep | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Clicking/popping in jaw | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Pain around the ear/earaches | <input type="checkbox"/> Headaches |

If you checked *any* of the above, please explain. _____

Billing Party Information

Complete if the person responsible for the account is NOT the patient.

Name: _____ SS#: _____
Address: _____ City: _____ State: _____ ZIP: _____
Employer: _____ How long? _____
Employer's address: _____ City: _____ State: _____ ZIP: _____
Occupation: _____ Work #: _____ Cell #: _____

Dental Insurance:

Address listed on card: _____ Subscriber name: _____
_____ * Subscriber SS#: _____
Phone number listed on card: _____ * Subscriber DOB: _____
ID: _____ Employer: _____
Group: _____

Communication Preferences

Phone: _____

Email for account and statements: _____

Email for appointments: _____

Emergency contact name: _____ Relationship: _____ Phone: _____

I give permission to discuss my treatment and orthodontic finances with the following people:

- Name: _____ Relationship to patient: _____
- Name: _____ Relationship to patient: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions on both pages have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the orthodontist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care to third party payer and/or health practitioners. I understand this may include the release of information concerning HIV testing, diagnosis, or treatment of AIDS, AIDS related conditions, drug or alcohol abuse or related conditions, any psychiatric and/or psychological conditions. I agree to be responsible for payment of all services rendered on my behalf. I understand that any balance carried on the house accounts after thirty (30) days from the date of service, will be charged interest on the unpaid balance at 1 ½ percent per month, compounded monthly, at an annual percentage rate of 18%. I understand that I am subject to credit checks before and/or during the course of treatment (includes new and current patients).

Signature of Patient/Parent/Guardian Date: _____

Media Consent

I grant Dr. Darcie R. Bradley, DMD, MS, Orthodontics permission to use my (or my children's) photos or videos taken before, during, or after treatment. These may be shared on social media, the office website, or other promotional materials to showcase patient smiles. Photos and videos will only be used by Dr. Bradley's office.

Signature of Patient/Parent/Guardian Date: _____

Acknowledgement: Receipt of Privacy Practices Notice

I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Parent/Guardian Date: _____