Adult New Patient Form

Today's Date: _____

Patient's Name: First_____Middle_____ Last_____

Birthdate: ____/____/_____ Age: _____ Gender: F____ M____ Marital Status: _____

Occupation: _____Employer: _____

Home Address: _____

Phone number: _____ Work phone: _____Cell phone: _____

E-mail address: _____

Spouse's Name_____

REASON FOR TODAY'S VISIT: _____

WHO MAY WE THANK FOR THIS REFERRAL? (Please check or fill in below)

INTERNET:_____ **DENTIST:**_____ **PATIENT:**_____ **INSURANCE CO:**_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address) : _____

Relationship:_____ Home phone :_____ Work phone:_____

DENTAL INSURANCE INFORMATION

Insured Name_____ Insured SSN or ID#: _____

Insurance company_____ Insurance co. address. _____

Secondary insurance? Yes____ No_____ If yes:

Insured Name_____ Insured SSN or ID#_____

Insurance Company_____ Insurance co. address. _____

MEDICAL HISTORY

Physician: _____

Address: _____Phone: _____

Please circle Yes or No:

Yes No Are you taking any medications? If yes, which one_____

Yes No ARE YOU ALLERGIC TO ANY MEDICATION OR MATERIAL **(e.g. latex, nickel)?**

If yes specify_____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operation? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Do you smoke or chewed tobacco?_____

Yes No Are you pregnant? Due date:_____

Circle any of the medical conditions below that you have had or currently have.

ADD/ADHD	Diabetes	Heart problem	Mental disorder (depression, anxiety, other)
Abnormal bleeding	Dizziness	Hepatitis (type __)	Radiation/chemotherapy
Anemia	Drug/alcohol abuse	High blood pressure	Syndrome (name_____)
Arthritis	Epilepsy	HIV/AIDS	Tuberculosis
Asthma	Gastrointestinal disorder	Kidney disease	Tumor/Cancer_____
Bone disorders	Hearing/visual problems	Lung disease	Other_____

Comments: _____

DENTAL HISTORY

Yes No Are you presently in any dental pain? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have there been any injuries to face, mouth or teeth?_____

Yes No Do you have any oral habits (mouth breathing, nail biting, thumbsucking, tongue habit?)

_____

Yes No Do you have any jaw or TMJ pain?_____

Yes No Do you grind or clench your teeth?_____

Yes No Do you have "tension" headaches?_____

Yes No Do you have any speech problems? _____

Yes No Has an orthodontist been consulted or provided treatment previously?_____

How many times/day do you brush your teeth?_____

How many times/day do you floss? _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Patient Signature_____Date_____

UPDATES TO MEDICAL HISTORY Changes: _____Date: _____Initials: _____

19735 Germantown Rd. Suite 140
Germantown, MD 20874

I hereby agree that Dr. Natalia Tomona may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions.

I understand that my insurance plan may have a maximum amount per year. Whereas this office may help me keeping an estimate of it, it will be my responsibility to contact the insurance company for more accurate and up to date information.

I understand that I am ultimately financially responsible for all charges whether or not they are covered by the insurance plan.

Copies of claims and/or insurance payments should be requested directly by me to the insurance company.

I have read the Notice of Privacy Practice and I am aware that I can request a copy of it at any time.

I consent to receive mail, electronic mail, telephone calls, and/or text messages from Dr. Natalia Tomona.

Dr. Natalia Tomona reserves the right to charge for appointments cancelled or broken without a 24-hour advance notice.

I fully understand the above statements; my signature below constitutes my agreement.

PRINT PATIENT NAME: _____

SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN: _____

DATE: _____

Orthodontic Treatment Clearance Form

So that we may provide the best orthodontic care possible, please complete this dental clearance form prior to orthodontic treatment

General Dentist Information:

Dr.:_____ Phone #:_____

Dentist Address: _____

Current Dental History:

Date of last examination: _____/_____/_____

Date of last cleaning: _____/_____/_____

Is this your first orthodontic consultation? ___ Y ___N
If no, did you apply for orthodontic coverage? ____Y ___N
If yes, were you approved or denied? _____

I have had a current examination by my general dentist for cavities/gum disease and have been cleared to start orthodontic treatment. I have been advised of the importance of routine cleanings and examinations throughout my orthodontic care.

_____ _____/_____/_____
Patient/Parent/Legal Guardian signature Date

***Regular dental care is important for everyone's dental health. Tomona Orthodontics, by following dental control guidelines from Centers of Disease Control and the American Dental Association, offers a comfortable and safe environment for dental care. Patients with questions or concerns are encouraged to call our office manager or Dr. Tomona at 301-540-6301. Tours of Central Sterilization are also available upon request.