MULLEN ORTHODONTICS
S. RUSSELL MULLEN DDS, MS
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS
(703) 771-9887 www.mullenortho.com

Orthodontic Acquaintance Card - Adult

Patient Name_____Nickname_____

Date of Birth_____/_____/_____Age_____M or F _____

Home Address_____Apt _____

City_____State_____Zip_____

Home Phone_(_____)_____Email_____

Patient's School_____Grade_____

Referred by_____Have you seen another orthodontist? ☐Y☐ N

Patient's Dentist_____Patient's Physician_____

Insurance Information:

Person or Persons Responsible for Account_____

Home Phone_(_____)_____

Address if Different from Patient_____

City_____State_____Zip_____

Dental Insurance Carrier_____

Does your insurer provide orthodontic coverage? ☐Y ☐ N ☐Unsure

Subscribers Name _____

Subscribers Social Security #_____

Subscribers DOB_____

Insurance ID #_____

Insurance Group #_____

Employer_____

Employer Address_____

City_____State_____Zip_____

Miscellaneous:

Have we seen any other members of your family?

Name(s): _____

What is the patient's attitude toward receiving orthodontic treatment? _____

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Medical History

Patient Name: _____

Is the patient in good health? ☐Y ☐N If no, explain_____

Does the patient have any history of major illness? ☐Y ☐N If yes, explain_____

_____

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

__ADD/ADHD	__Fainting or dizziness	__Transplants
__AIDS/HIV	__Heart murmur	__Artificial joints
__Asthma	__Heart disease	__Other_____
__Artificial Heart valve	__Hepatitis type: _____	_____
__Bone disorders	__Kidney disease	_____
__Bleeding abnormality	__Learning disability	_____
__Blood disease	__Liver disease	_____
__Cancer	__Nervous disorder	
__Chemical dependency	__Pneumonia	
__Diabetes	__Prolonged bleeding	
__Endocrine problems	__Rheumatic fever	
__Epilepsy	__Tuberculosis	

Please list any **surgeries**/hospitalizations that the patient has had_____

_____

Please list any **allergies** to food or medication:_____

_____

Is the patient allergic to latex? ☐Y ☐N Is the patient allergic to nickel? ☐Y ☐N

Does the patient have trouble wearing jewelry? ☐Y ☐N

Please list any **medications** the patient is taking currently_____

_____

Women Only: Are you pregnant? ☐Y ☐N Are you nursing? ☐Y ☐N

Dental History

Who is the patient's dentist?_____

When was the patient's last dental appointment?_____

Please describe any injuries to the face, mouth, or teeth the patient has had_____

_____

Has the patient ever sucked a thumb or fingers? ☐Y ☐N Until what age?_____

Does the patient still suck a thumb or fingers? ☐Y ☐N

Does the patient breathe through his/her mouth while awake? ☐Y ☐N

Does the patient breathe through his/her mouth while asleep? ☐Y ☐N

Have you been informed that the patient has any missing or extra teeth? ☐Y ☐N

_____ _____

Signature of Patient or responsible party Date

Dr. Mullen's comments:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

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

_____
Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited us from obtaining acknowledgement

☐ Other (please specify)

_____

_____

_____
Employee Signature

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Photo Permission Form

This form must be filled out.

I hereby give Mullen Orthodontics permission to photograph and use my or my minor child's photo for their website, Facebook page and within the Mullen Orthodontics office for promotional purposes.

I understand that I, or my minor child (under age 18), will not receive compensation for the use of this likeness in any form.

Please check below for permission:

- ❑ Mullen Orthodontics Facebook Page Permission
- ❑ Mullen Orthodontics Website Permission
- ❑ Mullen Orthodontics office walls
- ❑ All of the above
- ❑ None of the above

Patient Name

Name of Parent/Guardian (if applicable)

Signature of Patient/Parent Guardian

Date