

Patient Information (Adult)

Date: _____

Name: _____

Last

First

Middle

Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Birthday: ___/___/___ Age: _____

___ Male ___ Female SS#: _____ - _____ - _____ DL# _____

Home Address: _____

Apt./Condo #

City

State

Zip

Home#: (____) _____ Cell/Other#:(____) _____ Wk.#(____) _____ Ext. _____

___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Employer: _____ Occupation: _____

Employer's Address: _____

City

State

Zip

How long there? _____ Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____ Last Visit Date: _____

Dentist's Phone # (____) _____

Person Responsible for Account: _____

Spouse Information

Name: _____

Address:(If different from spouse) _____

City

State

Zip

SS#: _____ - _____ - _____ DL# _____ D.O.B.: ___/___/___

Wk.#(____) _____ - _____ Ext: _____ Hm. #(____) _____ - _____

Email: _____ Cell/Other#:(____) _____ - _____

Dental Insurance Information

Orthodontic Coverage? ___Y ___N Dental Coverage? ___Y ___N

Insured's Name: _____ Insured's SS# or ID#: _____ - _____ - _____

Insurance Company: _____ Group No. _____ Local No: _____

Insurance Co. Address _____ Phone #: (____) _____ - _____

City

State

Zip

Do you have dual coverage? ___Yes ___No If Yes:

Insured's Name: _____ Insured's SS# or ID#: _____ - _____ - _____

Insurance Company: _____ Group No. _____ Local No: _____

Insurance Co. Address _____ Phone #: (____) _____ - _____

City

State

Zip

Dental & Medical History

What are the main concerns that you would like orthodontic treatment to accomplish?

Has you ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

Do you require antibiotics before dental treatment? Y N

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

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

Do you ever have any pain/tenderness in your jaw joint (TMJ/TMD)? Y N

Your current dental health? Good Fair Poor

Do you still have wisdom teeth? Y N

Do you generally breathe through your mouth? Y N

If Yes: While Awake or While Asleep

Do you have any speech problems? _____

Are you happy with the way your smile looks? Y N

If not, what would you change? _____

Physician: _____

Phone#: _____ Date of Last Visit: _____

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

Please explain: _____

Your current physical health? Good Fair Poor

Do you smoke or use tobacco? Y N

Have you had any metal rods, pins or implants? Y N

Are you taking any prescriptions/over the counter drugs? Y N

Please list each one: _____

For Women:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week#: _____

Are you nursing? Y N

Have you ever experienced the following medical problems?

Y N Abnormal Bleeding

Y N Alcohol/Drug Abuse

Y N AIDS/ HIV+

Y N Anemia

Y N Arthritis

Y N Asthma

Y N Artificial Bones/Joints/Valves

Y N Blood Transfusion

Y N Colitis

Y N Cancer

Y N Congenital Heart Defect

Y N Convulsions

Y N Diabetes

Y N Epilepsy

Y N Emphysema

Y N Fainting Spells

Y N Frequent Headaches

Y N Glaucoma

Y N Hay Fever

Y N Hearing Impairments

Y N Handicaps/Disabilities

Y N Heart Attack/Surgery

Y N Heart Murmur

Y N Hepatitis

Y N Herpes/Fever Blisters

Y N High Blood Pressure

Y N Hospitalized

Y N Kidney Problems

Y N Liver Disease

Y N Low Blood Pressure

Y N Lupus

Y N Mitral Valve Prolapse

Y N Pacemaker

Y N Psychiatric Problems

Y N Radiation Treatment

Y N Rheumatic/Scarlet Fever

Y N Seizures

Y N Shingles

Y N Sickle Cell Disease/Traits

Y N Sinus Problems

Y N Stroke

Y N Thyroid Problems

Y N Tuberculosis (TB)

Y N Ulcers

Y N Venereal Disease

Please list any serous medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin

Y N Codeine Y N Jewelry/Metal Y N Tetracycline

Y N Dental Anesthetics Y N Latex Y N Other

Please list any other drugs/materials that you are allergic to: _____

Are you currently taking medication for osteoporosis? Y N

If so, the name? _____

Anything you would like to discuss with the Doctor in private? 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 that 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. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of th office, use the services of one or more credit reporting services.

Signature _____

Date _____

