

Patient Information – Adult

We would like to welcome you to our office. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible. Thank you for your cooperation.

Date: _____

Patient's Name: _____

Birth Date: _____

Prefers To Be Called: _____

Sex: Male Female

Address: _____

City, St, & Zip: _____

Home Phone #: _____

Cell Phone #: _____

Email Address: _____

Employer: _____

Work Phone #: _____

Sports And/Or Hobbies: _____

Musical Instruments Played: _____

Patient's Dentist: _____

City: _____

How did you hear about our office? _____

Who suggested that you might need orthodontic treatment? _____

What is your primary concern? _____

Other family members treated here: _____

Marital Status: Single Married Divorced Widowed

Spouse's Name: _____

Birth Date: _____

Employer: _____

Work Phone #: _____

Please complete the insurance information on the back

Insurance Information

Primary Policy Holder's Name: _____

Employed By: _____

Dental Insurance Company: _____

Address: _____

City, St, & Zip: _____

Secondary Policy Holder's Name: _____

Employed By: _____

Dental Insurance Company: _____

Address: _____

City, St, & Zip: _____

S.S.N.: _____

Insurance Coverage For Orthodontic Treatment? Yes No

Group No. _____

Insurance Identification #: _____

Phone No.: _____

S.S.N.: _____

Insurance Coverage For Orthodontic Treatment? Yes No

Group No. _____

Insurance Identification #: _____

Phone No.: _____

Medical History - Adult

Patient's Name: _____

Are you in good health? No Yes Explain: _____
Currently under physician's care? No Yes Explain: _____
Tonsils or adenoids been removed? No Yes Age: _____
Drug sensitivities? No Yes List: _____
Currently taking medications? No Yes List (dose): _____
Require antibiotics before dental treatment? No Yes List (dose): _____
Are you pregnant? No Yes Due Date: _____
Allergies?
 Ibuprofen Latex Antibiotics Acrylic Metals
 Other substance List: _____

Please check if there is a history of:

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Cardiovascular problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Nervous/Anxious
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Developmental Disorder
<input type="checkbox"/> Growth Disorders	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Endocrine Disorders
<input type="checkbox"/> Hereditary Problems	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes (fever blisters)
<input type="checkbox"/> High or Low Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Fainting	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Hives/Rash

Are there any other medical conditions that we should be aware of? _____

DENTAL HISTORY

Unfinished dental care? No Yes Explain: _____
Frightened about dental treatment? No Yes Explain: _____
Any facial or dental injuries? No Yes Explain: _____
History of thumb or finger sucking? No Yes Explain: _____
Have any teeth been removed? No Yes Explain: _____
Any Previous orthodontic treatment? No Yes Explain: _____
Consulted an orthodontist previously? No Yes Explain: _____
Any family member have treatment? No Yes Explain: _____

Please check here if there is a history of:

<input type="checkbox"/> Clenching teeth	<input type="checkbox"/> Muscular soreness	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Jaw joint popping	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Headaches (more than normal)
<input type="checkbox"/> Jaw joint clicking	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Snoring
<input type="checkbox"/> Jaw joint soreness	<input type="checkbox"/> Mouth Breathing	
	<input type="checkbox"/> Awake <input type="checkbox"/> Asleep	

Thank You

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)