

MIDDLETON ORTHODONTICS

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

ADULT PATIENT INFORMATION

Patient's Name (First, Middle, Last) _____ Age _____ Birthdate _____

Nickname (if preferred) _____ Male Female Patient's Home Phone _____

Patient's Home Address _____ City, State, Zip _____

How did you hear about our office? _____

Have we treated another member of your family? Yes No If YES, Name (First, Last) _____

Have you visited with an orthodontist before? Yes No If Yes, for what reason? _____

RESPONSIBLE PARTY INFORMATION

Name (First, Last) _____ Relationship _____

Address (Street, City, State, Zip) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email address _____

Employer _____ Employer Address _____

Name (First, Last) _____ Relationship _____

Address (Street, City, State, Zip) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email address _____

Employer _____ Employer Address _____

If you have insurance coverage, please fill out.

Insured Name (First, Last) _____

Relationship to Patient _____ Social Security Number _____ Date of Birth _____

Employer _____ Employer Address _____

Insurance Company _____ Group # _____ ID # _____

Insurance Company Address _____ Phone Number _____

EMERGENCY INFORMATION

Name of nearest relative not living with you (First, Last) _____ Relationship _____

Address (Street, City, State, Zip) _____ Phone # _____

ADULT DENTAL HISTORY

General Dentist Name _____ Date of last cleaning _____

Dentist address _____ Phone number _____

Do you require pre-medication antibiotics before dental treatment? Yes No If Yes, explain _____

Have your adenoids or tonsils been removed? Yes No Have you been informed of any missing or extra permanent teeth? Yes No

Have there been injuries to the face, mouth or chin? Yes No Have you ever had pain/tenderness in the jaw joint (TMJ/TMD)? Yes No

Do/Did you have any of the following?

Unfavorable Dental experience

Clenching or Grinding

Food impaction

Periodontal treatment

Mouth Breathing

Speech Problems

Chewing/Eating Problems

Tongue Thrust

Teeth sensitivity

Complications from extractions

Nicotine habit

Other: _____

ADULT MEDICAL HISTORY

Are you currently under the care of a physician? Yes No If Yes, for what reason? _____

Physician's name _____ Phone number _____

History of any major illness? Yes No If Yes, please describe _____

Are you allergic to Laxtex? Yes No Any other allergies? Yes No If Yes, please list: _____

Currently taking any medication? Yes No If Yes, please list: _____

(For Women) Are you currently pregnant? Yes No If Yes, how many months? _____

Have you been treated for any of the following?

Arthritis

High/Low blood pressure

Blood Disorder

Seasonal allergies

Diabetes

Epilepsy/Seizures

Heart Condition

HIV/AIDS

Liver problems/Hepatitis

Mitral Valve Prolapse

Nervous Disorder

Tuberculosis

Asthma

Cancer/Radiation treatment

Murmur/Rheumatic Fever

Artificial Joint

Please describe any current medical treatment including any medications not mentioned above: _____

SIGNATURE

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Responsible Party: _____

Relationship _____ Date _____