ADULT PATIENT INFORMATION

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

Spouse's Name ______________________________________ Phone# ______________________________

Nickname (if preferred) ____________________ O Male O 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? O Yes O No If Yes, Name (First, Last) ______________________

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

RESPONSIBLE PARTY INFORMATION

Name (First, Last) ______________________________________ Relationship ______________________

Address (Street, City, State, Zip) ____

Home # ____________________ Cell # ____________________ Email ____________________

Driver's Lic # ______________________________ Social Security # ______________________________

Employer ______________________________________ Work # ______________________________

Name (First, Last) ______________________________________ Relationship ______________________

Address (Street, City, State, Zip) ____

Home # ____________________ Cell # ____________________ Email ____________________

Driver's Lic # ______________________________ Social Security # ______________________________

Employer ______________________________________ Work # ______________________________

If you have DENTAL 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? O Yes O No If Yes, explain ____________________

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

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

Do/Did you have any of the following?

O Unfavorable Dental experience
O Clenching or Grinding
O Food impaction
O Periodontal treatment
O Mouth Breathing
O Speech Problems
O Chewing/Eating Problems
O Tongue Thrust
O Teeth sensitivity
O Complications from extractions
O Nicotine habit
O Other: ____________________

ADULT MEDICAL HISTORY

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

Physician's name ____________________ Phone number ____________________

History of major illness or Medical Condition? O Yes O No If Yes, please describe____________________

Currently taking medication? O Yes O No If Yes, please list & explain:____________________

Are you allergic to LATEX? O Yes O No Any other allergies? O Yes O No If Yes, please list:____________________

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

Have you been treated for any of the following?

O Arthritis
O High/Low blood pressure
O Blood Disorder
O Seasonal allergies
O Diabetes
O Epilepsy/Seizures
O Heart Condition
O HIV/AIDS
O Liver problems/Hepatitis
O Mitral Valve Prolapse
O Nervous Disorder
O Tuberculosis
O Asthma
O Cancer/Radiation treatment
O Murmur/Rheumatic Fever
O Artificial Joint

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

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Race (optional) O African American O American Indian O Asian O Caucasian O Chinese O Japanese O Korean O Latin O South Pacific

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 medical status.

SIGNATURE

Relationship ____________________ Date ____________________