ADULT PATIENT INFORMATION

Patient's name: _____
Last First Middle

Residence: _____
Street City Zip

Mailing Address: _____
Street City Zip

Home phone:_____ Work phone:_____ Cell Phone:_____

Email Address:_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Birthdate:_____ Employer:_____Occupation:_____ No. years employed: ____

Spouse's Name:_____ Relationship to Patient:_____

Employer:_____ Occupation:_____ No. years employed: ___

Birthdate:_____ Phone:_____

Whom may we thank for referring you to our office? _____

I authorize the following individuals to have complete access to my patient records and to my account information:

_____

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

Insured's Name:_____ Insured's Birth Date: _____Relationship to Patient:_____

Group No.:_____ ID# or SS#:_____

Insurance Company:_____ Insurance Co. City & State: _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name:_____ Insured's Birth Date: _____Relationship to Patient:_____

Group No.:_____ ID# or SS#:_____

Insurance Company: _____ Insurance Co. City & State: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Complete address:_____
Street City Zip

MEDICAL HISTORY

Physician: _____ Date of Last Visit: _____
Address: _____ Phone: _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist: _____ Date of last visit: _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during work hours? _____

CONSENT

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

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Signature: _____ Date: _____