Adult Patient Information

The benefits of a happy, healthy smile are immeasurable.
Our goal is to make everyone's visit pleasant and educational.
Please fill out the information below:

Today's Date _____

Name _____ SS# _____
LAST FIRST MI MR. MRS. MS. DR.

I prefer to be called _____ Birth date _____ Age _____ ☐ Male ☐ Female

Home address _____
STREET APT./CONDO # CITY STATE ZIP CODE

E-mail _____ Home # _____ Cell # _____

Employer _____ Phone # _____

Employer's address _____
STREET CITY STATE ZIP CODE

Occupation _____ Where/when are the best times to reach you? _____

Whom may we thank for referring you? _____

Please list your other family members seen by us _____

General dentist _____ Date of Last Visit _____

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name _____ SS# _____ Birth date _____

E-mail _____ Employer _____ Work # _____

Person Responsible for Account _____ SS# _____

Home # _____ Relationship _____

Billing Address _____
STREET APT./CONDO # CITY STATE ZIP CODE

Previous Address _____
STREET APT./CONDO # CITY STATE ZIP CODE

Primary Dental Insurance Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS# _____

Policy Owner's Relation _____ Employer _____

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Secondary Dental Insurance Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS# _____

Policy Owner's Relation _____ Employer _____

Health History

What are the main concerns that you would like the orthodontist to address? _____

_____

Have you ever been evaluated for or had orthodontic treatment before? ☐ Yes ☐ No
Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No
Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
Do you now, or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Do you like your smile? ☐ Yes ☐ No Do your gums bleed ☐ Yes ☐ No
Please describe your current dental health ☐ Good ☐ Fair ☐ Poor
For women: Are you pregnant? ☐ Yes ☐ No Week # _____ Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases/medical problems?

☐ Yes ☐ No Allergic to latex/metals	☐ Yes ☐ No Emphysema	☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Allergies to any drugs	☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Kidney/liver problems
☐ Yes ☐ No Anemia	☐ Yes ☐ No Heart attack/stroke	☐ Yes ☐ No Mitral valve prolapse
☐ Yes ☐ No Arthritis	☐ Yes ☐ No Heart murmur	☐ Yes ☐ No Radiation treatment
☐ Yes ☐ No Asthma	☐ Yes ☐ No Heart surgery/pacemaker	☐ Yes ☐ No Rheumatic/scarlet fever
☐ Yes ☐ No Cancer/chemotherapy	☐ Yes ☐ No Hemophilia/abnormal bleeding	☐ Yes ☐ No Seizures/epilepsy/fainting
☐ Yes ☐ No Congenital heart defect	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Diabetes	☐ Yes ☐ No High/low blood pressure	☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Difficulty breathing		

Please list any serious medical conditions that you have _____

Physician name _____ Phone # _____

Date of last visit _____ Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

Please describe your current physical health ☐ Good ☐ Fair ☐ Poor

Please list any prescriptions/over the counter drugs you are taking _____

Please list any drugs/materials/foods/flavorings (mint, cinnamon, etc.) that you are allergic to _____

_____

I understand the information I have given 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 _____ Date _____

Doctor's Comments _____

_____

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