

PATIENT FORM (ADULT)

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

PATIENT INFORMATION

Name _____ Sex ☐ M ☐ F ☐ OTHER
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

E-mail _____ Birthdate _____
MM/DD/YY

Marital Status _____

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

Dentist _____ Last Visited _____

How did you hear about our practice? ☐ ADVERTISEMENT ☐ FAMILY/FRIEND ☐ INTERNET ☐ DENTIST ☐ OTHER

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

Please list any other family members seen in our office: _____

Emergency Contact Information

Name _____
LAST FIRST MIDDLE

E-mail _____

Primary # _____

DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____

Policy Owner's Birth Date _____

Policy Owner's Employer _____

Policy Owner's Address _____

Relationship to Patient _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____

Policy Owner's Address _____

Policy Owner's Birth Date _____

Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

MEDICAL AND DENTAL HISTORY

Are you under the care of a physician? ☐ YES ☐ NO If yes, explain: _____

Physician _____ Phone _____ Last Visit _____

Are you pregnant? ☐ YES ☐ NO If so, how many weeks? _____

What are your main concerns that you would like orthodontics to accomplish?

Have you ever been evaluated for orthodontic treatment? ☐ YES ☐ NO If yes, explain: _____

Have your tonsils or adenoids been removed? ☐ YES ☐ NO Have you experienced jaw joint pain/discomfort (TMJ/TMD)? ☐ YES ☐ NO

Do you have any missing or extra permanent teeth? ☐ YES ☐ NO

Have you ever had injury to ☐ TEETH ☐ MOUTH ☐ CHIN If yes, explain: _____

Do you have speech problems? ☐ YES ☐ NO If yes, explain: _____

Do your gums bleed? ☐ YES ☐ NO Do you smoke or use electronic cigarettes? ☐ YES ☐ NO Do you like your smile? ☐ YES ☐ NO

Do you have any of the following habits?

☐ LIP SUCKING/BITING

☐ PROLONGED BOTTLE/PACIFIER

☐ MOUTH BREATHER

☐ THUMB/FINGER SUCKING

☐ NAIL BITING

☐ CLENCHING/GRINDING TEETH

☐ TONGUE THRUSTING

☐ CHEWING/EATING PROBLEM

Are you allergic to any of the following?

☐ METALS/PLASTICS

☐ DENTAL ANESTHETICS

☐ LATEX

☐ OTHER

MEDICAL AND DENTAL HISTORY CONTINUED

List all the drugs you are currently taking: This would include prescriptions, diet, or over-the-counter medications. Please include the dosage.

Have you ever taken any medications to strengthen your bones, such as a bisphosphonate? ☐ YES ☐ NO

Please describe any serious medical condition(s): This would include any allergies, serious illnesses, operations, hospitalizations, or surgeries.

Have you ever had any of the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> HIGH BLOOD PRESSURE | |
| <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> PERSISTENT COUGH | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> COUGHING BLOOD | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> SICKLE CELL DISEASE/TRAITS |
| <input type="checkbox"/> ARTIFICIAL BONES/JOINTS/VALVES | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EPILEPSY/SEIZURES/FAINTING | <input type="checkbox"/> MISTRAL VALVE PROLAPSE | <input type="checkbox"/> SWELLING OF FEET OR ANKLES |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> FEVER BLISTERS/HERPES | <input type="checkbox"/> PSYCHIATRIC PROBLEMS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RADIATION TREATMENT | <input type="checkbox"/> TOBACCO HABIT |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> HEART ATTACK/STROKE | <input type="checkbox"/> RESPIRATORY DISEASE | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CANCER/CHEMOTHERAPY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RHEUMATIC/SCARLET FEVER | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HEART SURGERY/PACEMAKER | <input type="checkbox"/> RHEUMATISM | <input type="checkbox"/> ULCERS/COLITIS |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> SEVERE/FREQUENT HEADACHES | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HEPATITIS | | |

SIGNATURE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by _____ Date _____