

FOR ADULTS: WELCOME TO OUR PRACTICE

1.) ABOUT YOU

Today's date: _____ DOB: _____
Name: _____ AGE: _____

Last _____ First _____ MI (Mr. Mrs. Ms.) _____
I preferred to be called: _____

Home #: _____
Work #: _____
SS #: _____
DL #: _____

Home Address:

Apt# _____

City State Zip

2.) ABOUT YOUR EMPLOYER:

Name: _____
Address: _____

How long have you worked there? _____
Occupation: _____

When & Where are the best times to reach you? _____
Other family members seen by us: _____

Who may we THANK for referring you? _____

3.) SPOUSE INFORMATION:

Name: _____
Employer: _____
WK#: _____
DL#: _____
SS#: _____
DOB: _____

DENTAL INFORMATION:

Previous/Present Dentist: _____
Street: _____
Phone: _____ Last visit: _____

4.) RESPONSIBLE PARTY INFO:

Name: _____
Billing address: _____

City State Zip
WK#: _____ Ext. _____ HM#: _____
Employer: _____
DL #: _____
SS #: _____

Emergency Contact:

Name: _____ Relation: _____
Wk#: _____ Ext. _____ HM# _____

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____
Ins. Address: _____

Insurance Co. Phone #: _____
Group/Policy # _____

Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: _____
Ins. Address: _____

Insurance Co. Phone #: _____
Group/Policy # _____

Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
Orthodontic Coverage: YES NO

6.) DENTAL HISTORY

Why have you come to the orthodontist today? _____

Are you currently in pain? Y N

You current dental health is:
 Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?
 Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? _____

A day do you brush? _____

Types of bristles? Hard Medium Soft

7) MEDICAL HISTORY

Do you have a personal physician? Y N

Name: _____

Phone: _____ Last visit: _____

Your current physical health is:
 Good Fair Poor

Are you currently under the care of a doctor?
 Y N Explain: _____

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Weeks #: _____

Are you nursing? Y N

8.) Have you ever had any of the following diseases or medical problems?

Y N Prothesis	Y N History of Scarlet Fever
Y N Heart attack	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum. Fev.	Y N Artificial Valves
Y N HIV+/AIDS	Y N Heart surgery/Packmkr.
Y N Hemophilia	Y N Any Stays in Hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Mitral Valve Prolapse
Y N Tuberculosis	Y N Artificial bones/joints
Y N Shingles	Y N Sev./Freq. headaches
Y N Fever blister	Y N Hi/Lo blood pressure
Y N Venereal dis.	Y N Drug/Alcohol Abuse
Y N Ulcers/Colitis	Y N Blood Transfusion
Y N Heart Murm.	Y N Anemia/Radiation tmt.
Y N Emphysema	Y N Glaucoma
Y N Sinus Probs.	Y N Difficulty Breathing?
Y N Other:	

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin
Y N Codeine	Y N Dental Anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.
 Initials: _____ Date: _____

Medical History Update:
 1. Date: _____ Signature: _____

Comments: _____

Doctor's comments: _____

2. Date: _____ Signature: _____

Comments: _____