

# WELCOME TO OUR OFFICE

## ADULT PATIENT INFORMATION

Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthdate: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Do you know a patient currently in our practice? If so, whom: \_\_\_\_\_

Who noticed your orthodontic problem? You Dentist Other \_\_\_\_\_

Describe your orthodontic problem in your own words: \_\_\_\_\_

What concerns you most about orthodontic treatment?

Appearance in appliances cost length of time discomfort results other \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_ Wk. Phone \_\_\_\_\_

How long with this employer? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Family And Account Information

Spouses Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk phone: \_\_\_\_\_

Person responsible for account: \_\_\_\_\_

*If other than self or spouse:*

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## INSURANCE INFORMATION

If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office, so that you may be reimbursed directly by your insurance carrier.

Name of insured (Employee): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of insured (Employee): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_

**Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.**

**MEDICAL HISTORY**

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- Have you ever experienced any health problems? No Yes Explain: \_\_\_\_\_
- Any major change in your health recently? No Yes Explain: \_\_\_\_\_
- Are you currently under a physician's care? No Yes Explain: \_\_\_\_\_
- Are you currently taking any medications? No Yes List: \_\_\_\_\_
- Are you allergic to any medications? No Yes List: \_\_\_\_\_
- Have you received a blood transfusion? No Yes Reason: \_\_\_\_\_
- Have your tonsils or adenoids been removed? No Yes When: \_\_\_\_\_

Please check if you have had any of the following conditions:

Heart Murmur/Surgery...	No	Yes	Hepatitis.....	No	Yes	Emotional Problems....	No	Yes
AIDS.....	No	Yes	Diabetes.....	No	Yes	Frequent Headaches....	No	Yes
Rheumatic Fever.....	No	Yes	Kidney Disease...	No	Yes	Nervous/Anxious.....	No	Yes
Endocrine disorders.....	No	Yes	Liver Disease.....	No	Yes	Cancer.....	No	Yes
Prolonged Bleeding.....	No	Yes	Tuberculosis.....	No	Yes	Bone Disorders.....	No	Yes
Anemia.....	No	Yes	Bronchitis.....	No	Yes	Growth Disorders.....	No	Yes
Blood Disease.....	No	Yes	Asthma.....	No	Yes	Mouth Breather.....	No	Yes
Developmental Disorder.	No	Yes	Epilepsy.....	No	Yes	Herpes (Fever Blisters).	No	Yes
Hives/Rash.....	No	Yes	Fainting.....	No	Yes	Tonsillitis.....	No	Yes

Is there any other condition or problem that you think we should know about? \_\_\_\_\_

**DENTAL HISTORY**

Dentist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Specialist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental checkups: 2 times a year 1 time a year Only if problem exists Never Date of Last Visit: \_\_\_\_\_

- Is there any unfinished care to be completed with your dentist? No Yes Explain: \_\_\_\_\_
- Are you frightened about dental treatment? No Yes Explain: \_\_\_\_\_
- Have you had an unpleasant experience in the dental office? No Yes Explain: \_\_\_\_\_
- Have you had any facial or dental injuries? No Yes Explain: \_\_\_\_\_
- Do you play any musical instruments? No Yes What instrument: \_\_\_\_\_
- Have you consulted an orthodontist previously? No Yes With whom: \_\_\_\_\_
- Have teeth (either primary or permanent) been removed? No Yes
- Have you had any previous orthodontic treatment? No Yes With whom: \_\_\_\_\_
- Are you satisfied with prior treatment? No Yes Explain: \_\_\_\_\_
- Any changes in your bite or dental alignment recently? No Yes Explain: \_\_\_\_\_

Please check if there is a history of:

Clenching teeth	Muscular Soreness around head & neck	Jaw joint soreness	Jaw joint popping
Grinding teeth	Headaches (more than normal)	Jaw joint clicking	Ring in the ears
Speech problems (if so what sounds _____)		Mouthbreathing	Awake _____ Asleep _____

Is there any other information which may be helpful? \_\_\_\_\_

**I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date