PATIENT INFORMATION-ADULT

Welcome to our office!

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, which is important for our records and your health, is confidential. Thank you.

Patient's Name _____ Sex_____
FIRST MIDDLE LAST

Home Address _____ Home #_____
STREET CITY ZIP CODE

Patient's Occupation or School_____Age_____ Birthdate_____

Person Responsible for Account _____Home # _____ Cell #_____

Relationship_____ Employer_____ Work #_____ E-Mail_____

Name of person to be contacted if patient cannot be reached:

Name_____Phone #_____

Insurance

Is patient covered by insurance for orthodontic treatment? (Yes/No)

Insurance Company_____Address_____

Phone_____Employer_____Group/Policy #_____

Insured Name_____SS #_____Birth Date_____Relationship_____

Family History

Marital Status_____

Spouse's Name_____

Names and Ages of Children _____

Father Living?_____ Health_____ Mother Living?_____ Health_____

Medical History

Height_____ Weight_____ Patient's Physician_____ Phone_____

Has the patient ever had:

Asthma	Diabetes	Hearing Disorder	HIV
Anemia	Epilepsy	Heart Disease	Rheumatic Fever
Birth Defects	Endocrine Problems	Hepatitis	Other (describe below)
Blood Disease/Hemophelia	Emotional Problems	Herpes	
Bone Disorders	Head or Face Injury	High or Low Blood Pressure	

COMMENTS:

_____

_____

Has the patient been under the care of a physician during the past two years, other than for routine examination? Yes No

Condition:_____

Present drugs or medication: _____

Are you currently taking or have you ever taken any bisphosphonates?_____

Any allergies or reactions to any medication? _____

Any known allergies? (Yes/No) Specify:_____

Mouth breathing habit, snoring or difficulty in breathing? (Yes/No)

Have frequent colds, sore throat, or "stuffy nose"? (Yes/No)

Smoke (Yes/No) Any other tobacco products (Yes/No)

Has the patient received medical treatment from an allergist or ear, nose and throat specialist? (Yes/No)

Specify:_____

Dental History

Patient's Dentist_____ Date of last dental checkup_____

Were the patient's teeth cleaned?_____ Were full mouth or panoramic x-rays taken?_____

Does the patient have pain or clicking in jaw joint? (TMJ) (Yes/No)

Have any teeth been injured due to accidents or blows to the mouth? (Yes/No)

Has the patient had or been advised to have speech correction? (Yes/No)

Thumb, finger, or sucking habit? (Yes/No) Until what age?_____

Has the patient had any unusual dental experiences? (Yes/No) Specify:_____

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

Orthodontic History

Has the patient had previous orthodontic consultation or treatment? Yes No

Date:_____ Dr:_____

Patient's interest in orthodontic treatment: Wants Treatment Treatment If Necessary Unwilling But Agrees

What is the primary problem?_____

Additional comments you wish to make:_____

_____

Signature of individual completing this form:_____Date_____