

Patient Information --- **ADULT**

PLEASE PRINT

DATE ____/____/____

• Patient _____
FIRST MIDDLE LAST

M ___ F ___ Birthdate _____ Age _____

Phone (____) _____ - _____

Email _____

Address _____

City _____ Zip _____

Single ___ Married ___ Divorced ___

Children _____

Employed by _____

Position _____

Employer Address _____

Employer Phone (____) _____ - _____

• Spouse _____

Email _____ Phone (____) _____ - _____

Employed by _____ Position _____

Employer Address _____ Employer Phone (____) _____ - _____

General Dentist: _____ Phone: (____) _____ - _____

Last Visit: _____

How did you hear about our practice? Ad Internet Family/Friend Physician Insurance Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to correct?

Have you visited an orthodontist before? Yes No If yes, when? _____

Reason _____

Have we treated any other family members? Yes No

Name(s) _____

DENTAL INSURANCE COVERAGE

Employee Name _____

Employee D.O.B (xx/xx/xxxx) _____

Employee SSN _____ - _____ - _____

Employer Name _____

Employer Phone _____

Name of Insurance Co. _____

Insurance Co. Address

Insurance Co. Phone _____

Member ID Number _____

Policy or Group # _____

Employee Relationship to Patient _____

Dental History:

Do you or have you ever had any of the following habits (circle all that apply)

Clenching/Grinding Teeth	Lip Sucking/Biting	Mouth Breathing	Nail Biting
Thumb/Finger Sucking	Chewing/Eating Problem	Swallowing Problems	Smoking
• TONSILS ---	PRESENT	REMOVED	WHEN _____
• ADENIODS ---	PRESENT	REMOVED	WHEN _____

Have you ever experienced any missing or extra permanent teeth? _____

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? _____

Have you ever had an injury to (circle all that apply): Teeth Mouth Chin

Do you have any speech problems?
If so, explain: _____

Medical History:

Are you currently being treated by a physician? Yes No
Reason: _____
Physician Name: _____ Phone: _____

Do you have any allergies/sensitivities to medications or latex? Yes No
If yes, please list _____

Do you need/use an EPI Pen? Yes No

Are you currently taking any prescription or over-the-counter medications? Yes No
If yes, please list _____

Have you had any serious illnesses or operations? Yes No
If yes, please describe _____

Have you ever had a blood transfusion? Yes No
If yes, give approximate dates: _____

Circle if you have ever had any of the following:

- | | | | |
|-------------------|---------------|--------------|-------------------------|
| Anemia | Asthma | Autism | Blood Disorder |
| Cough, Persistent | Diabetes | AIDS | Kidney or liver disease |
| Arthritis | Heart Trouble | T.B. | Rheumatic Fever |
| Hepatitis | Epilepsy | Brain Injury | Hearing Difficulties |
| Other | | | |

Authorization

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 pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

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

Signature: _____ Date: _____