Patient Information --- **ADULT**

PLEASE PRINT

DATE _____/_____/_____

- Patient _____
  FIRST MIDDLE LAST

M___ F____ Birthdate_____ Age_____

SSN: _____-_____-_____

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 (_____)_____-_____

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_____

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 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: _____