

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 (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Emergency Contact (if other than spouse): \_\_\_\_\_ 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)**

Abnormal Breathing	Nail Biting	Tongue Biting	Grinding Teeth
Smoking	Tongue Sucking	Lip Sucking/Biting	Speech Disorders
Tongue Thrusting	Mouth Breathing	Thumb/Finger Sucking	Tobacco Use (in any form)
• TONSILS ---	PRESENT	REMOVED	WHEN _____
• ADENIODES ---	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: \_\_\_\_\_

(Women) Are you pregnant?      Yes                      No                      Nursing?      Yes                      No

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:**

AIDS	Anemia	Arthritis	Artificial bones/joints/valves	Autism Sensory
Asthma	Blood disorders	Brain injury	Cancer / Cancer medication	Diabetes
Dizziness/Fainting		Drug/Alcohol Abuse	Emphysema	Epilepsy
Glaucoma	Handicap or Disabilities		Hearing Impairment	Heart Attack
Heart Congenital Defect		Heart Murmur	Heart Surgery or Pacemaker	Heart Trouble
Hemophilia or Abnormal Bleeding		Hepatitis or Jaundice	Herpes	High Blood Pressure
Kidney Disease		Low Blood Pressure	Mitral Valve Prolapse	Periodontal Disease
Psychiatric Problem		Radiation Therapy	Respiratory Therapy	Respiratory Problems
Rheumatic Fever	Seizures	Shingles	Sickle Cell Disease	Stomach Troubles or Ulcers
Stroke	Thyroid Problem	Tuberculosis	Frequently Tired	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: \_\_\_\_\_