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: _____

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_____

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 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 _____
- 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:_____

(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: _____