

FOR ADULTS: WELCOME TO OUR PRACTICE

1) TELL US ABOUT YOU

Today's date: _____ DOB _____

Name: _____ Age: _____

Last First Mi (Mr. Mrs. Ms.)

I prefer to be called: _____

Home #: _____

Work #: _____

SS #: _____

DL #: _____

Home Address:

Apt # _____

City State Zip

4) RESPONSIBLE PARTY INFO:

Name: _____

Billing Address: _____

City State Zip

WK#: _____ Ext _____ HM# _____

Employer: _____

~~DL#:~~ _____

SS#: _____

EMERGENCY CONTACT:

Name: _____

WK#: _____ Ext _____ HM# _____

2) ABOUT YOUR EMPLOYER

Name: _____

Address: _____

How long have you worked there? _____

Occupation: _____

When and where are the best times to reach you? _____

Other family members seen by us: _____

Who may we THANK for referring you? _____

5) PRIMARY DENTAL INSURANCE:

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: Yes No

3) SPOUSE INFORMATION:

Name: _____

Employer: _____

WK#: _____

~~DL#:~~ _____

SS#: _____

DOB: _____

DENTAL INFORMATION:

Previous/Present Dentist: _____

Street: _____

Phone: _____ Last Visit: _____

SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy #: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's DOB: _____

Insured's Employer: _____

SS#: _____

Orthodontic Coverage: Yes No

6) DENTAL HISTORY:

Why have you come to the Orthodontist today? _____

Are you currently in pain? Yes No

Your current dental health is:

Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? ... Yes No

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

A day do you brush? _____

Types of bristle? Hard Medium Soft

MEDICAL HISTORY

Do you have a personal physician? Yes No

Name: _____

Phone: _____ Last Visit: _____

Your current physical health is:

Good Fair Poor

Are you currently under the care of a doctor? . Yes No

Explain: _____

Are you taking prescription drugs? Yes No

FOR WOMEN ONLY:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

7) HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS:

- | | | | | | |
|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Prosthesis | <input type="checkbox"/> | <input type="checkbox"/> | History of Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Def. |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheum. Fever | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Valves |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery / Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Any Stays in Hospital |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Kidney / Liver failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones / Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> | Sev. / Freq Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blister | <input type="checkbox"/> | <input type="checkbox"/> | Hi / Lo Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal Dis. | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers/Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murm. | <input type="checkbox"/> | <input type="checkbox"/> | Anemia/Radiation Tmt. |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ | | | |

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- | | | | | | |
|--------------------------|--------------------------|------------|--------------------------|--------------------------|--------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature _____

Date _____

Payment is due in full at time of treatment unless prior arrangements have been made.

OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent/guardian and patient named herein.

Initials: _____ Date: _____

Doctors comments: _____

Medical History Update:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____