ADULT PATIENT INFORMATION (CONFIDENTIAL)

DATE: _____

Name: _____ Prefers to be called: _____
First M. Last

Date of Birth: _____ Age: _____ Gender: Male/Female

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

General Dentist (include city & state): _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Mailing Address: _____

Whom may we thank for referring you? _____

Primary reason for seeking orthodontic treatment: _____

Do you have reservations about having your teeth straightened? Appearance __ Cost __ Pain __ Time __

Have any members of your family been patients in our office? Yes/No Name(s):_____

Has any family member had orthodontics before? Yes/No Who was the orthodontist? _____

RESPONSIBLE FINANCIAL PARTY INFORMATION

Name: _____ Relationship to Patient: _____
First M. Last

Gender: _____ Date of Birth: _____ SS #: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact Person: _____
Name Relationship Phone

ORTHODONTIC INSURANCE INFORMATION

PATIENT NAME: _____ **DATE:** _____

☐**Yes** ☐**No** Does the patient have Orthodontic Coverage?

☐**Yes** ☐**No** Does the patient have Dental Coverage?

Primary Orthodontic Coverage

Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone #: (_____) _____

Group # (Plan, Local or Policy #):_____

Insured's Name: _____

Relation to Patient: _____

Insured's Birthdate: _____/_____/_____ Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Orthodontic Coverage

Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone #: (_____) _____

Group # (Plan, Local or Policy #):_____

Insured's Name: _____

Relation to Patient: _____

Insured's Birthdate: _____/_____/_____ Insured's SS#: _____

Insured's Employer: _____

Employer's Address: _____

MEDICAL INFORMATION

Physician: _____ Date of Last Visit: _____

Address: _____ Office Phone: _____

Now or in the past, has the patient had?

☐**Yes** ☐**No** ☐**Unsure** AIDS or HIV positive?

☐**Yes** ☐**No** ☐**Unsure** Anemia?

☐**Yes** ☐**No** ☐**Unsure** Arthritis?

☐**Yes** ☐**No** ☐**Unsure** Asthma?

☐**Yes** ☐**No** ☐**Unsure** Birth defects or hereditary problems?

☐**Yes** ☐**No** ☐**Unsure** Behavioral, Emotional or Learning disorders?

☐**Yes** ☐**No** ☐**Unsure** Bleeding disorders?

☐**Yes** ☐**No** ☐**Unsure** Bone disorders?

☐**Yes** ☐**No** ☐**Unsure** Bone fractures?

☐**Yes** ☐**No** ☐**Unsure** Cancer or tumors?

☐**Yes** ☐**No** ☐**Unsure** Diabetes?

☐**Yes** ☐**No** ☐**Unsure** Dizziness?

☐**Yes** ☐**No** ☐**Unsure** Eating disorders?

☐**Yes** ☐**No** ☐**Unsure** Endocrine disorders?

☐**Yes** ☐**No** ☐**Unsure** Epilepsy?

☐**Yes** ☐**No** ☐**Unsure** Fainting spells?

☐**Yes** ☐**No** ☐**Unsure** Gastrointestinal disorders?

☐**Yes** ☐**No** ☐**Unsure** Headaches?

☐**Yes** ☐**No** ☐**Unsure** Hepatitis?

☐**Yes** ☐**No** ☐**Unsure** Herpes?

☐**Yes** ☐**No** ☐**Unsure** Heart trouble?

☐**Yes** ☐**No** ☐**Unsure** High blood pressure?

☐**Yes** ☐**No** ☐**Unsure** Immune disorders?

☐**Yes** ☐**No** ☐**Unsure** Kidney disorders?

☐**Yes** ☐**No** ☐**Unsure** Liver disorders?

☐**Yes** ☐**No** ☐**Unsure** Muscle disorders?

☐**Yes** ☐**No** ☐**Unsure** Nervous disorders?

☐**Yes** ☐**No** ☐**Unsure** Rheumatic Fever?

☐**Yes** ☐**No** ☐**Unsure** Tonsil or Adenoid conditions?

☐**Yes** ☐**No** ☐**Unsure** Tuberculosis?

Allergies or reactions to any of the following:

☐**Yes** ☐**No** ☐**Unsure** Ibuprofen

☐**Yes** ☐**No** ☐**Unsure** Latex

☐**Yes** ☐**No** ☐**Unsure** Vinyl

☐**Yes** ☐**No** ☐**Unsure** Acrylic

☐**Yes** ☐**No** ☐**Unsure** Metals?

☐**Yes** ☐**No** ☐**Unsure** Foods or flavorings?
Specify:_____

☐**Yes** ☐**No** ☐**Unsure**
Other:_____

Medications:

☐**Yes** ☐**No** ☐**Unsure** Is the patient taking medication, nutrient supplements, herbal medications or nonprescription medicine? Please name them and what they are taken for:

_____

_____

Women and Girls only:

☐**Yes** ☐**No** ☐**Unsure** Has the patient started her monthly periods? Approximately when? _____

☐**Yes** ☐**No** ☐**Unsure** Is the patient pregnant?

Are there any major illnesses or medical conditions not mentioned above that we should be aware of?

_____

DENTAL INFORMATION

Dentist: _____ Office Phone: _____

Address: _____

Date of last visit: _____ Frequency of visits: _____

How many times a day does the patient brush their teeth? _____ Floss their teeth? _____

Now or in the past, has the patient had?

☐**Yes** ☐**No** ☐**Unsure** Prior orthodontic examination or treatment?

☐**Yes** ☐**No** ☐**Unsure** Started teething very early or late?

☐**Yes** ☐**No** ☐**Unsure** Teeth sensitive to hot or cold?

☐**Yes** ☐**No** ☐**Unsure** Chipped or injured baby or permanent teeth?

☐**Yes** ☐**No** ☐**Unsure** Jaw fractures or other trauma to the neck, head and jaw area?

☐**Yes** ☐**No** ☐**Unsure** Tooth grinding and/or jaw clenching?

☐**Yes** ☐**No** ☐**Unsure** Jaw popping and/or clicking?

☐**Yes** ☐**No** ☐**Unsure** Pain in jaw when chewing or ringing in ear?

☐**Yes** ☐**No** ☐**Unsure** Pain or soreness in the muscles of the face or around the ears?

☐**Yes** ☐**No** ☐**Unsure** Chronic neck pain?

☐**Yes** ☐**No** ☐**Unsure** Difficulty encountered in chewing or jaw opening?

☐**Yes** ☐**No** ☐**Unsure** History of speech problems? Been under the care of a speech therapist?

☐**Yes** ☐**No** ☐**Unsure** Mouth breathing habit?

☐**Yes** ☐**No** ☐**Unsure** Snoring or difficulty breathing?

☐**Yes** ☐**No** ☐**Unsure** Abnormal swallowing habit (tongue thrusting)?

☐**Yes** ☐**No** ☐**Unsure** Thumb, finger or lip sucking habit? Until what age? ____

☐**Yes** ☐**No** ☐**Unsure** Frequent cancer sores or cold sores?

☐**Yes** ☐**No** ☐**Unsure** Gums bleed when brushed or flossed?

☐**Yes** ☐**No** ☐**Unsure** Wisdom teeth extracted?

☐**Yes** ☐**No** ☐**Unsure** Extra or missing teeth from birth?

☐**Yes** ☐**No** ☐**Unsure** Periodontal “gum problems”?

☐**Yes** ☐**No** ☐**Unsure** Been under the care of a dental specialist? Specialist: _____

☐**Yes** ☐**No** ☐**Unsure** Taking any forms of fluoride?

☐**Yes** ☐**No** ☐**Unsure** Any serious trouble associated with previous dental treatment?

☐**Yes** ☐**No** ☐**Unsure** Any relative with similar tooth or jaw relationships?

☐**Yes** ☐**No** ☐**Unsure** Sensitive or self-conscious about teeth?

Are there any dental conditions not mentioned above that you feel we should be aware of?

_____
_____

I certify that the information on this form is true and correct to the best of my knowledge, that it will be held in the strictest of confidence, and I will notify you of any changes.

Signature: _____ **Date:** _____