FOR ADULTS: WELCOME TO OUR PRACTICE

1) ABOUT YOU

Today's date: _____ DOB: _____

Name: _____ AGE: _____

Last First Mi (Mr. Mrs. Ms.)

I preferred to be called: _____

Home #: _____ Cell #: _____

Work #: _____

SS #: _____

DL #: _____

Home Address:

_____

Apt #

_____

City State Zip

2) ABOUT YOUR EMPLOYER:

Name: _____

Address: _____

_____

How long have you worked there? _____

Occupation: _____

When & Where are the best times to reach you?

_____

Other family members seen by us:

_____

Who may we THANK for referring you?

_____

3) SPOUSE INFORMATION:

Name: _____

Employer: _____

WK #: _____

DL #: _____

SS #: _____

DOB: _____

DENTAL INFORMATION:

Previous/Present Dentist: _____

Street: _____

Phone: _____ Last Visit: _____

4) RESPONSIBLE PARTY INFO:

Name: _____

Billing Address: _____

_____

City State Zip

_____

WK#: Ext. HM #:

Employer: _____

DL #: _____

SS #: _____

Emergency Contact:

Name: _____ Relation: _____

WK # _____ Ext. _____ HM #: _____

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

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? Y N
Your current dental health is:
Good Fair Poor
Have you ever had a serious/difficult problem associated with previous dental work? Y N
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?
Y N
Do you like your smile? Y N
Do your gums ever bleed? Y N
How many times a week do you floss? _____
A day do you brush? _____
Types of bristles? Hard Medium Soft

7) MEDICAL HISTORY

Do you have a personal physician? Y N
Name: _____
Phone: _____ Last Visit? _____
Your current physical health is:
Good Fair Poor
Are you currently under the care of a doctor?
Y N Explain: _____
Are you taking any prescription drugs? Y N

FOR WOMEN ONLY:

Are you taking birth control pills? Y N
Are you pregnant? Y N Week #: _____
Are you nursing? Y N

8) Have you ever had any of the following diseases or medical problems?

Y N Prosthesis	Y N History of Scarlet Fever
Y N Heart Attack	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy/ Seizure
Y N Diabetes	
Y N Rhuem. Fev.	Y N Abnormal Bleeding
Y N HIV+/AIDS	Y N Artificial Valves
Y N Hemophilia	Y N Heart surgery/Pacmkr.
Y N Asthma	Y N Any Stays in Hospital
Y N Hepatitis	Y N Kidney/Liver Problems
Y N Tuberculosis	Y N Mitral Valve Prolapse
Y N Shingles	Y N Artificial bones/joints
Y N Fever blister	Y N Sev./Freq. headaches
Y N Venereal dis.	Y N Hi/Lo blood pressure
Y N Ulcers/Colitis	Y N Drug/Alcohol Abuse
Y N Heart Murm.	Y N Blood Transfusion
Y N Emphysema	Y N Anemia/Radiation tmt.
Y N Sinus Probs.	Y N Difficulty breathing?
Y N Glaucoma	

Other physical or psychological issues?
_____
_____
_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin
Y N Codeine	Y N Dental Anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other:

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 I may need during treatment.

_____
Signature Date

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

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.
Initials: _____ Date: _____

Doctor's comments: _____
_____

Medical History Update:
1. Date: _____ Signature: _____
Comments: _____

2. Date: _____ Signature: _____
Comments: _____

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