ADULT PATIENT INFORMATION

Today's Date ______________________

Patient Name ______________________________ Nickname ______________
First Middle Last

S.S. Number ____________________ ☐ Male ☐ Female Date of Birth ______________ Age ________

Address ____________________________ City ______________ State ______ Zip ________

Home Phone ____________ Business Phone ____________ Cell Phone ____________ Carrier ____________

Employed By/Occupation ______________________ ☐ single ☐ married ☐ separated ☐ divorced ☐ widow(er)

Would you like to receive text reminders or email reminders? ☐ Text ☐ Email

Email Address ____________________________ Have we treated a family member? ______________

Whom may we thank for referring you? ______________________________

Name of General Dentist ______________________________ Date of Last Visit ______________

What are your primary goals for orthodontic treatment? ______________________________

Is this your first visit to an Orthodontist? ☐ Yes ☐ No

Emergency Contact Name ____________________ Relationship ____________ Phone ______________

DENTAL INSURANCE INFORMATION

Insured's Name ____________________ Insured's SS# ____________ Insured's Date of Birth ____________

Insured's Relationship to Patient ______________________ Insured's Employer ______________

Dental Insurance Company ______________________ Dental Insurance Co.'s Phone Number ______________

Dental Insurance Company Address ______________________________________

ID Number ____________________________ Group Number ____________________________

Do you have secondary coverage? Yes ☐ No ☐ If yes, please complete:

Insured's Name ____________________ Insured's SS# ____________ Insured's Date of Birth ____________

Insured's Relationship to Patient ______________________ Insured's Employer ______________

Dental Insurance Company ______________________ Dental Insurance Co.'s Phone Number ______________

Dental Insurance Company Address ______________________________________

I, the undersigned, understand that responsibility for payment of Orthodontic Services provided for myself or my dependent is mine, but you will assist me with financial arrangements and Dental Dental Insurance claims when necessary. I agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of the account. IF CREDIT IS EXTENDED FOR ORTHODONTIC FEES, YOUR CREDIT STATUS MAY BE VERIFIED BY A CREDIT AGENT.

Signature ______________________________ Date ______________________

JAY HARRIS ORTHODONTICS

MEDICAL HISTORY

Today's Date ______________________

Patient's Name ______________________

Please circle Y (yes) or N (no) for the following questions. Your answers are for our records only and will be kept strictly confidential. Please use the space after the question or on the back of the form for additional explanation, if necessary.

MEDICAL HISTORY

Are you in good general health? ______________________

Has there been any change in your general health within the last year? ______________________

Last Physical Exam: ______________ (Month/Year)

Are you currently under the care of a physician?

If so, what is being treated? ______________________

Have you had a serious illness/hospitalization in the past 5 years?

If so, for what? ______________________

Are you taking any medication (include non-prescription)?

If so, for what? ______________________

Do you have any of the following conditions, allergies, or drug reactions to:

Y N Latex
Y N Penicillin, Sulfa Drugs, or other Antibiotics
Y N Nickel or Other Metals
Y N Aspirin, Ibuprofen, Tylenol
Y N Local Anesthetics
Y N Codeine or Other Narcotics
Y N Other
Y N Respiratory Problems, Emphysema
Y N Asthma or Hay Fever
Y N Sinus Trouble
Y N Persistent Swollen Neck Glands
Y N Thyroid or Endocrine Problems
Y N Diabetes
Y N Hepatitis, Jaundice, or Liver Disease
Y N AIDS or HIV Infection
Y N Sexually Transmitted Disease
Y N Substance Abuse Problem (past or present)
Y N Mental Health Problem or Nervous Disorder
Y N Fainting Spells or Seizures
Y N Epilepsy or Other Neurological Disorder
Y N Blood Disorder such as Anemia
Y N Abnormal Bleeding or Blood Transfusion

Y N Low Blood Pressure
Y N Cardiovascular Disease (Heart Trouble, Heart Attack, Angina, High Blood Pressure, Arteriosclerosis, Stroke)
Y N Damaged or Artifical Heart Valves, Including Heart Murmur or
Y N Rheumatic Heart Disease
Y N Do you require antibiotic pre-medication prior to dental visits?
Y N Arthritis, Joint Problems, or Artificial Joints/Limbs
Y N Birth Defects
Y N Kidney Trouble
Y N Tuberculosis
Y N Bone Fractures or Trauma to Face or Jaw
Y N Vision, Hearing, or Speech Difficulty
Y N Persistent Cough
Y N Frequent Colds or Sore Throats
Y N Frequent Headaches
Y N Stomach Ulcer or Hyperacidity
Y N Tumor (Cancerous or Benign)
Y N Radiation Therapy or Chemotherapy
Y N Tonsils or Adenoids Removed? What age?
Y N FEMALES Are you pregnant?

Y N Have you ever taken Bisphosphonates or other Osteoporosis medication (Fosamax, Boniva, Actonel, Etc.)?

Y N Do you have any disease, condition, or problem not listed above that you think we should know about?

If so, please explain: ______________________

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