



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 _____ Cell 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 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 _____



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 Low Blood Pressure |
| Y N Penicillin, Sulfa Drugs, or other Antibiotics | Y N Cardiovascular Disease (Heart Trouble, Heart Attack, Angina, High Blood Pressure, Arteriosclerosis, Stroke) |
| Y N Nickel or Other Metals | Y N Damaged or Artificial Heart Valves, Including Heart Murmur or |
| Y N Aspirin, Ibuprofen, Tylenol | Y N Rheumatic Heart Disease |
| Y N Local Anesthetics | Y N Do you require antibiotic pre-medication prior to dental visits? |
| Y N Codeine or Other Narcotics | Y N Arthritis, Joint Problems, or Artificial Joints/Limbs |
| Y N Other | Y N Birth Defects |
| Y N Respiratory Problems, Emphysema | Y N Kidney Trouble |
| Y N Asthma or Hay Fever | Y N Tuberculosis |
| Y N Sinus Trouble | Y N Bone Fractures or Trauma to Face or Jaw |
| Y N Persistent Swollen Neck Glands | Y N Vision, Hearing, or Speech Difficulty |
| Y N Thyroid or Endocrine Problems | Y N Persistent Cough |
| Y N Diabetes | Y N Frequent Colds or Sore Throats |
| Y N Hepatitis, Jaundice, or Liver Disease | Y N Frequent Headaches |
| Y N AIDS or HIV Infection | Y N Stomach Ulcer or Hyperacidity |
| Y N Sexually Transmitted Disease | Y N Tumor (Cancerous or Benign) |
| Y N Substance Abuse Problem (past or present) | Y N Radiation Therapy or Chemotherapy |
| Y N Mental Health Problem or Nervous Disorder | Y N Tonsils or Adenoids Removed? What age? |
| Y N Fainting Spells or Seizures | Y N FEMALES Are you pregnant? |
| Y N Epilepsy or Other Neurological Disorder | |
| Y N Blood Disorder such as Anemia | |
| Y N Abnormal Bleeding or Blood Transfusion | |
| 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: _____

