ADULT PATIENT INFORMATION

Date _____

Patient's Name _____
LAST FIRST MIDDLE

Residence _____
STREET CITY ZIP

Mailing Address _____
STREET CITY ZIP

Previous Address (If less than 3 years) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Email Address _____

Social Security # _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ Cell Phone _____

Employer _____ Occupation _____

Years Employed _____ Social Security # _____ Birth Date _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Phone _____ Do you have dual coverage? ☐ Yes ☐ No If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Phone _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to Patient _____ Phone _____

Address _____
STREET CITY ZIP

I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____

Updates (Date & Initial): _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please check Yes or No (If Yes, please fill in details)

☐ Yes ☐ No Are you taking any medication? _____

☐ Yes ☐ No Are you allergic to any medication? _____

☐ Yes ☐ No Do you have a history of a major illness? _____

☐ Yes ☐ No Have you had any operations? _____

☐ Yes ☐ No Have you ever been involved in a serious accident? _____

☐ Yes ☐ No Have you ever smoked or chewed tobacco? _____

☐ Yes ☐ No Have seen a physician in the last 12 months? Why? _____

Female patients only:

☐ Yes ☐ No Are you pregnant? _____

☐ Yes ☐ No Has menstruation started? _____

Check any of the medical conditions below that you have had or currently have:

☐ Abnormal bleeding	☐ Herpes	☐ Hay-fever	☐ Kidney problems
☐ Hemophilia	☐ Prolonged bleeding	☐ Gastrointestinal disorders	☐ Tuberculosis
☐ Diabetes	☐ Arthritis	☐ HIV	☐ Congenital Heart Defect
☐ Hepatitis/Liver problems	☐ Epilepsy	☐ Aids	☐ Heart murmur
☐ Pneumonia	☐ High blood pressure	☐ Rheumatic Fever	☐ Nervous disorders
☐ Anemia	☐ Radiation/Chemotherapy	☐ Bone disorders	☐ Tumor / Cancer
☐ Dizziness	☐ Asthma	☐ Heart problems	☐ Other

Are there any other medical conditions we have not discussed that you feel we should be aware of? _____

_____

Signature: _____ Date: _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

☐ Yes ☐ No Are you presently in any dental pain? _____

☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry? _____

☐ Yes ☐ No Have your wisdom teeth been removed? _____

☐ Yes ☐ No Have you ever lost or chipped any teeth? _____

☐ Yes ☐ No Have there been any injuries to face, mouth, or teeth? _____

☐ Yes ☐ No No Is any part of your mouth sensitive to temperature? Where? _____

☐ Yes ☐ No Is any part of your mouth sensitive to pressure? Where? _____

☐ Yes ☐ No Do your gums bleed when you brush? _____

☐ Yes ☐ No Do you have any type of thumb or tongue habit? _____

☐ Yes ☐ No Are you a mouth breather? _____

☐ Yes ☐ No Have you ever seen an orthodontist? If yes, who and when? _____

☐ Yes ☐ No What is your attitude toward receiving orthodontic treatment? _____

☐ Yes ☐ No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

☐ Yes ☐ No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

☐ Yes ☐ No Are you aware of your jaw clicking or popping? _____

☐ Yes ☐ No Are you aware of clenching your teeth during the day? _____

☐ Yes ☐ No Have you ever been told that you grind your teeth? _____

☐ Yes ☐ No Do you have “tension” headaches? _____

☐ Yes ☐ No Have you ever experienced chronic ringing in your ears? _____

☐ Yes ☐ No Are you aware that some appointments will be during work hours? _____

Signature: _____ Date: _____