ADULT PATIENT INFORMATION

Date ______________________ Chart # ______________________

Name ____
Last First Initial Preferred Name

Address ____
Street City State Zip

Date of Birth ______________ Age ________ Sex __________ Phone ______________

Dentist ______________________ Physician ______________________

Address ______________________ Address ______________________

Phone ______________________ Phone ______________________

What is the reason for seeking orthodontic treatment? ______________________

____

Have you seen other orthodontists concerning the problem in the past? Yes ☐ no ☐

Does anyone in your family have a similar dental problem? Yes ☐ no ☐

Has anyone in your family had orthodontic treatment? Yes ☐ no ☐

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

Please list any special interests (sports, hobbies, pastimes, etc.) ______________________

____

RESPONSIBLE PARTY INFORMATION

Name ____
Last First Middle Marital Status

Residence ____
Street City State Zip

Mailing address ____
Street City State Zip

Home Phone ______________________ Work Phone ______________________

Preferred Method of Contact: ☐ Phone ______________ ☐ E Mail ______________

Social Security # ______________ Birthdate ______________ Relationship to patient ________

Employer ______________ Occupation ______________ No. Yrs.. Employed ________

Spouses Name ____________________________ Relationship to Patient ________
Last First Middle

Employer ______________ Occupation ______________ No. Yrs.. Employed ________

Social Security # ______________ Birthdate ______________ Work Phone ______________

DENTAL INSURANCE INFORMATION

Policy Holder's Name ______________ Birthdate ____________ Policy Holder's Soc Sec # ______________

Insurance Company ______________ Group No. ____________ Phone No. ______________

Insurance Co. Address ____

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

Policy Holder's Name ______________ Birthdate ____________ Policy Holder's Soc Sec # ______________

Insurance Company ______________ Group No. ____________ Phone No ______________

Insurance Co. Address ____

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

Signature ____

Updates (date & Initial) __________ __________ __________ __________ __________

-over-

MEDICAL HISTORY

Date of last physical examination ____________

Are you currently under the care of a physician? _________ If so, why? ______________________________________

____

Are you taking any medication now? ___________________ If so, for what? ___________________________________

Has the patient ever been treated for any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	AIDS or HIV +	☐	☐	Thyroid Problems	☐	☐
Pneumonia	☐	☐	Tuberculosis	☐	☐	Endocrine Problems	☐	☐
Heart Problems	☐	☐	Anemia	☐	☐	Prolonged Bleeding	☐	☐
Rheumatic Fever	☐	☐	Epilepsy	☐	☐	Liver Problems	☐	☐
Bone Disorders	☐	☐	Asthma	☐	☐	Fainting or Dizziness	☐	☐
Hepatitis	☐	☐	Kidney Problems	☐	☐	Mental Illness	☐	☐
Attention Deficit Disorder	☐	☐				Depression	☐	☐

Do you often have colds ☐, sore throats ☐, or ear infections ☐?

	Yes	No
Do you have any difficulty in breathing through your nose?	☐	☐
Have the tonsils and adenoids been removed? at what age? _________	☐	☐

Please list any allergies and/or drug sensitivities ____

Please describe any present or past medical problems. hospitalizations or operations:

____

Do you have any special problems that have not been mentioned above? ___________________________

____

DENTAL HISTORY

	Yes	No
When did you last visit your dentist? ______________ were x-rays taken?	☐	☐
Have there been any injuries to the face, mouth, or teeth?	☐	☐

Please explain ____

	Yes	No
Have you had any teeth (baby or permanent) removed by a dentist?	☐	☐
Do you have any of the following habits? lip biting ☐ pencil biting ☐	☐	☐

fingernail biting ☐ Other ____________________

	Yes	No
1. Have you had speech ☐ or tongue thrust ☐ therapy?	☐	☐
2. Do you have any speech problems at the present time?	☐	☐
3. Are your teeth or gums sensitive?	☐	☐
4. Do your gums bleed easily?	☐	☐
5. Do you have pain or difficulty when chewing, talking, or using your jaw?	☐	☐
6. Do you have pain in or about the jaws,ears,temples,or cheeks?	☐	☐
7. Do you have frequent headaches?(more than 1 per week)?	☐	☐
8. Does your jaw “catch or lock” when opening wide, for instance yawning?	☐	☐
9. Are you aware of noises in your jaw joints?	☐	☐
10. Has your bite felt uncomfortable or unusual?	☐	☐
11. Are you aware of clenching or grinding during the day or night?	☐	☐
12. Have you been previously treated for a jaw joint problem? If so when? ____________________	☐	☐
13. Do you have arthritis?	☐	☐
14. Have you had a recent injury to your jaw,head or neck?	☐	☐