



ADULT PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home phone _____ Work phone _____

Cell Phone _____ Birthdate: _____ SSN# _____

Email _____ Marital Status: Single__ Married__

Employer _____ Occupation _____

Spouse's Name _____

Employer _____ Occupation _____

SSN# _____ Birthdate _____ Work#: _____

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

DENTAL INSURANCE INFORMATION

Insured's Name _____ SSN# _____

Insurance Company _____ Group No. _____ Local# _____

Claims mailing Address _____

Phone No. _____ Do you have dual coverage? Yes___ No___ If yes:

Insured's Name _____ SSN # _____

Insurance Company _____ Group No. _____ Local#. _____

Claims mailing Address _____

Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Phone _____ Cell _____

Signature _____



MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle 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? _____

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

DENTAL HISTORY

Former Dentist _____ 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 there been any injuries to face, mouth, or teeth? _____

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

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

Yes / No How often do you floss? _____

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 or night? _____

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? _____

BENEFITS

Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

In addition, I authorize Dr. _____ to perform a complete oral evaluation.

Signature: _____ Date: _____