

FOR ADULTS: WELCOME TO OUR PRACTICE

Please bring completed form to your appointment.

1.) ABOUT YOU			
Today's date: _____		DOB: _____	
Name: _____		AGE: _____	
Last	First	MI	(Mr. Mrs. Ms.)
I preferred to be called: _____			
Home #: _____			
Work #: _____			
SS #: _____			
DL #: _____			
Home Address:			
			Apt#
City	State	Zip	

4.) RESPONSIBLE PARTY INFO:			
Name: _____			
Billing address: _____			
City	State	Zip	
WK#:	Ext.	HM#	
Employer: _____			
DL#: _____			
SS#: _____			
Emergency Contact:			
Name: _____		Relation: _____	
WK#:	Ext.	HM#:	

2.) ABOUT YOUR EMPLOYER:	
Name: _____	
Address: _____	
How long have you worked there? _____	
Occupation: _____	
When & Where are the best times to reach you? _____	
Other family members seen by us: _____	
Who may we THANK for referring you? _____	

5) PRIMARY DENTAL INSURANCE:	
Ins. Name: _____	
Ins. Address: _____	
Insurance Co. Phone #: _____	
Group/Policy # _____	
Insured's Name: _____	
Relationship to Patient: _____	
Insured's DOB: _____	
Insured's Employer: _____	
SS#: _____	
Orthodontic Coverage:	YES NO

3.) SPOUSE INFORMATION:	
Name: _____	
Employer: _____	
WK#: _____	
DL#: _____	
SS#: _____	
DOB: _____	
DENTAL INFORMATION:	
Previous/Present Dentist: _____	
Street: _____	
Phone: _____	Last visit: _____

SECONDARY DENTAL INSURANCE	
Ins. Name: _____	
Ins. Address: _____	
Insurance Co. Phone #: _____	
Group/Policy # _____	
Insured's Name: _____	
Relationship to Patient: _____	
Insured's DOB: _____	
Insured's Employer: _____	
SS#: _____	
Orthodontic Coverage:	YES NO

6) DENTAL HISTORY

Why have you come to the
orthodontist today? _____

Are you currently in pain? Y N

Your current dental health is:

Good Fair Poor

Have you ever had a serious/difficult problem
associated with previous dental work? Y N

**Have you ever had any pain or
tenderness in the jaw joint (TMJ/TMD)?**

Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? _____

A day do you brush? _____

Types of bristles? Hard Medium Soft

7) MEDICAL HISTORY

Do you have a personal physician? Y N

Name: _____

Phone: _____ Last visit: _____

Your current physical health is:

Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain: _____

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

8) Have you ever had any of the following diseases or medical problems?

Y N Prothesis Y N History of Scarlet Fever

Y N Heart attack Y N Congenital Heart Def.

Y N Cancer Y N Convulsions/Epilepsy

Y N Diabetes Y N Abnormal Bleeding

Y N Rheum. Fev. Y N Artificial Valves

Y N HIV+/AIDS Y N Heart surgery/Pacmkr.

Y N Hemophilia Y N Any Stays in Hospital

Y N Asthma Y N Kidney/Liver Problems

Y N Hepatitis Y N Mitral Valve Prolapse

Y N Tuberculosis Y N Artificial bones/joints

Y N Shingles Y N Sev./Freq. headaches

Y N Fever blister Y N Hi/Lo blood pressure

Y N Venereal dis. Y N Drug/Alcohol Abuse

Y N Ulcers/Colitis Y N Blood Transfusion

Y N Heart Murm. Y N Anemia/Radiation tmt.

Y N Emphysema Y N Glaucoma

Y N Sinus Probs. Y N Difficulty Breathing?

Y N Other: _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin

Y N Codeine Y N Dental Anesthetics

Y N Latex Y N Tetracycline

Y N Penicillin Y N Other: _____

**Our office is committed to meeting or
exceeding the standards of infection control
mandated by OSHA, the CDC, and the ADA.**

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical / dental
information above with the parent/guardian &
patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____

Medical History Update:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____