

FOR ADULTS: WELCOME TO OUR PRACTICE

| | | | |
|--|-------|------------|------|
| 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: _____ | |
| 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: _____