

FOR ADULTS: WELCOME TO OUR PRACTICE

1. ABOUT YOU

Today's date: _____ Age: _____ DOB: _____

Mr Mrs Ms Dr

Name: _____
Last First Middle

I preferred to be called: _____

Home#: _____ Cell#: _____

Email: _____ Work#: _____

SS#: _____

Home Address:

City State Zip

2. ABOUT YOUR EMPLOYER

Name: _____

Address: _____

How long you have worked there? _____

Occupation: _____

When & where are the best times to reach you? _____

Other family members seen by us: _____

Whom we may THANK for referring you? _____

3. SPOUSE INFORMATION

Name: _____

Employer: _____

WK#: _____ DL#: _____

SS#: _____

DOB: _____

DENTAL INFORMATION

Previous / Present Dentist: _____

Street: _____

Phone#: _____ Last Visit: _____

4. RESPONSIBLE PARTY INFO

Name: _____

Billing address : _____

City State Zip

WK#: _____ Home#: _____

Cell#: _____ Email: _____

Employer: _____

SS#: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

WK#: _____ Ext#: _____

Cell#: _____ Home#: _____

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

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? Yes No

Your current dental health is: Good Fair Poor

Have you ever had any serious/difficult problem associated with previous dental work? Yes No

Have you ever had pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____

How many times a day do you brush? _____

Types of bristles: Hard Medium Soft

7. MEDICAL HISTORY

Do you have a personal physician? Yes No

Name: _____

Phone #: _____ Last Visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a doctor? Yes No

Explain: _____

Are you taking any prescription drugs? Yes No

FOR WOMEN ONLY:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week#: _____

Are you nursing? Yes No

8. HEALTH HISTORY

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Prothesis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Def.
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Artificial valves
<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery/pacmkr
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Any Stays in Hospital
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial bones / joints
<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Sev./freq. headaches
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blister	<input type="checkbox"/>	<input type="checkbox"/>	Hi / low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug / alcohol abuse
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers / colitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Radiation tx
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

11. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aspirin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	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 medical status.

Signature _____ Date: _____

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: _____

1. Date: _____ Signature: _____

Comments: _____