ADULT PATIENT INFORMATION

Date _____ Pt# _____ Chrt # _____

Patient's Name: _____ Male / Female Birthdate _____ Age _____
First Middle Last Nickname

Address _____ Home Phone _____
Street City ST Zip

How long at this address _____ Previous Address (if less than 3 yrs) _____
Street City ST Zip

Social Security # _____ Marital Status S / M / D Cell Phone _____

Employer _____ Occupation _____ Work Phone _____ No. Years Employed ____

Email: _____ Names of Children _____

Dentist _____ Whom may we thank for referring you? _____

Has any member of family undergone Orthodontic Treatment? Y / N Who & Where? _____

SPOUSE INFORMATION

Name: _____ Male / Female Birthdate _____
First Middle Last

Social Security # _____ Employer _____ Occupation _____

Work Phone _____ No. Years Employed _____

ORTHODONTIC INSURANCE INFORMATION

Primary Policy Holder's Name: _____ S.S.# _____ Birthdate _____

Insured's Employer _____ Occupation _____ Relationship to Patient _____

Work Address _____ Work Phone _____
Street City ST Zip

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Company's Address _____ Ins. Code# _____
(OFFICE USE)

Do you have dual coverage? Yes No

Secondary Policy Holder's Name: _____ S.S.# _____ Birthdate _____

Insured's Employer _____ Occupation _____ Relationship to Patient _____

Work Address _____ Work Phone _____
Street City ST Zip

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Company's Address _____ Ins. Code# _____
(OFFICE USE)

EMERGENCY INFORMATION

Name _____ Relationship to Patient _____ Phone _____

Address _____ Cell Phone _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I understand credit bureau reports will be obtained for financial arrangements.

Signature _____ **Date** _____

MEDICAL HISTORY

Are you in good health? Yes / No Reason: _____

Any major or unusual illnesses or surgery? Yes / No Explain: _____

List any allergies or drug sensitivities _____

Currently taking medication? Yes / No List: _____

Have you been under the care of a physician during the last two years? Yes / No Explain: _____

Name of physician: _____

Please check box if you have or have had any of the following:

- ☐ Adenoids Removed When _____
- ☐ Anemia
- ☐ Asthma or Hay Fever
- ☐ Birth Defects
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Prolonged Bleeding
- ☐ Bone Disorders
- ☐ Colds (Frequent)
- ☐ Cancer
- ☐ Chewing or Swallowing Difficulty
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Faintness/Dizziness
- ☐ Frequent Cold/Flu
- ☐ Headaches (more than normal)
- ☐ Hearing Disorders
- ☐ Heart Disease or Murmur
- ☐ Hepatitis
- ☐ Herpes/Venereal Disease
- ☐ In the risk group for HIV+ / Aids
- ☐ Jaundice
- ☐ Joint Swelling
- ☐ Kidney Involvement
- ☐ Mononucleosis
- ☐ Rheumatic Fever
- ☐ Rickets
- ☐ Sore Throat (Frequent)
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tonsils removed
- ☐ When _____
- ☐ Tuberculosis
- ☐ Other

Explain any: _____

Additional comments: _____

DENTAL HISTORY

Please check box and circle if answer us YES

- ☐ Thumb, finger, lip sucking? Stopped? When _____
- ☐ Chewing or biting nails, objects?
- ☐ Mouth-breathing when asleep, awake?
- ☐ A tongue-thrust problem?
- ☐ High Decay Rate?
- ☐ Any missing permanent teeth?
- ☐ Any extra permanent teeth?
- ☐ Any teeth removed by extraction?

Have you had any injuries to head, face, jaw, chin, mouth, or teeth? Explain: _____

Have any teeth been injured due to accidents or blows to the mouth? Y / N Explain: _____

Have you received or been requested to receive speech correction? Y / N Explain: _____

Have you experienced problems with previous dental work? Explain: _____

Do you visit your dentist regularly? _____ Date of last visit: _____ Date of last dental cleaning: _____

How do you feel about wearing braces? _____

Have you had a previous orthodontic consultation Y / N or Treatment? Y / N Date: _____ Dr. _____

Orthodontic consultation prompted by: Self Spouse Child Dentist Sibling Physician Friend

Has your dentist pointed to an orthodontic problem? _____

What do you consider to be the main orthodontic problem? _____

What would you like to have orthodontic treatment accomplish? _____

Is there any other information that might be helpful? _____

TEMPOROMANDIBULAR AND FACIAL PAIN INFORMATION

Please check box and circle if answer is YES

Jaw Joint:

- ☐ Pain / Soreness / Popping / Clicking on opening?
- ☐ Makes noise so that it disturbs you or others?
- ☐ Gets stuck so that you can't open freely, "locked" or slipped out of place?
- ☐ Hurts to chew or open wide to take a big bite?
- ☐ "Feels tired" after a big meal or dental visit?
- ☐ Does pain or discomfort interfere with your daily routine / activities / disturb your sleep?

Ear Problems:

- ☐ Ringing / Hearing / Dizziness
- ☐ Earaches or Pain in front of the ears?
- ☐ Do you clench your teeth? Day or Nighttime
- ☐ Are your teeth sore or sensitive
- ☐ Do you have muscular soreness around Head / Neck?
- ☐ Must you chew exclusively on one side?
- ☐ Are you a habitual gum chewer or pipe smoker?