PATIENT INFORMATION (ADULT)

Date:_____

Patient's Name:_____
Last First Mi.

Address:_____
Street City Zip

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail:_____ Birthdate:_____ Age:_____

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

RESPONSIBLE PARTY INFORMATION

Name:_____
Last First Mi.

Mailing address (if different than patient):_____
Street City Zip

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail:_____ Social Security#: _____

Driver License #_____Relationship to Patient:_____

Employer:_____ Occupation:_____

Spouse's Name:_____
Last First Mi.

Mailing address (if different than patient):_____
Street City Zip

Home Phone:_____ Work Phone: _____ Cell Phone:_____

E-mail:_____ Social Security#: _____

Driver License #_____ Relationship to Patient:_____

Employer:_____ Occupation: _____

DENTAL INSURANCE

Insured's Name_____ Date of Birth:_____Subscriber #_____

Insurance Company_____ Group #_____ Local #_____

Insurance Co Address:_____ _____Phone #_____

Insured's Name_____Date of Birth:_____Subscriber #_____

Insurance Company_____ Group #_____ Local #_____

Insurance Co Address:_____Phone #_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____Phone #_____

Address_____Relationship:_____

DENTAL HISTORY

Dentist_____Phone_____ Date of last visit_____

Why have you come to the Orthodontist today?_____
Have you ever had a serious/difficult problem associated with dental work? Yes No
Are you currently in pain? 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
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No Your current health is? Good Fair Poor

Physician:_____Date of Last Visit:_____

Address:_____Phone:_____
Please circle Yes or No (if yes, please fill in details)
YES NO Are you taking any medications?_____
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 major operations?_____
YES NO Have you ever been involved in a serious accident?_____
YES NO Are you pregnant? Week #_____ Are you nursing? YES NO
Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Emphysema	Mitral Valve Prolapse
Anemia	Epilepsy	Nervous Disorders
Artificial Valves	Fever Blister	Pneumonia
Arthritis	Gastrointestinal Disorders	Prosthesis
Artificial Bones	Glaucoma	Radiation/Chemotherapy
Asthma/Hayfever	Handicaps/Disabilities	Rheumatic Fever
Blood Transfusion	Hearing Impairment	Scarlet Fever
Bone Disorders	Heart Attack	Severe/Frequent Headaches
Cancer	Heart surgery/Pacemaker	Shingles
Congenital Heart Defect	Heart Murmur	Sinus Problems
Convulsions/Epilepsy	Hemophilia	Tuberculosis
Diabetes	Hepatitis/Liver Problems	Tumor
Difficulty Breathing	High/Lo Blood Pressure	Ulcers/Colitis
Dizziness	HIV/AIDS	Venereal Disease
Drug/Alcohol Abuse	Kidney Problems	

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

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. I also authorize the dental staff to perform the necessary dental services I may need.

_____ _____
Signature of patient Date

I verbally reviewed the medical/dental information above with the patient named herin.

Initials_____ Date_____

Doctor's Comments:_____

Medical History Update:
1) Date_____ Signature_____ Comments_____

2) Date_____ Signature_____ Comments_____