

**FOR ADULTS: WELCOME TO OUR PRACTICE**

<b>1) ABOUT YOU</b>			
Today's date: _____	DOB: _____		
Name: _____	AGE: _____		
Last _____	first _____	Mi _____	(Mr. Mrs. Ms.) _____
I preferred to be called: _____			
Home #: _____			
Work #: _____			
SS #: _____			
DD #: _____			
<b>Home Address:</b>			
_____			Apt# _____
_____	_____	_____	_____
City	State	Zip	

<b>2) RESPONSIBLE PARTY INFO:</b>		
Name: _____		
Billing address: _____		
_____	_____	_____
City	State	Zip
WK#: _____	Ext. _____	HM#: _____
Cell #: _____		
Email: _____		
Employer: _____		
DL#: _____		
SS#: _____		
<b>Emergency Contact:</b>		
Name: _____		Relation: _____
WK#: _____	Ext. _____	HM#: _____

<b>2) ABOUT YOUR EMPLOYER:</b>
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? _____

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

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

**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 physician 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 the 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: \_\_\_\_\_