

FOR ADULTS: WELCOME TO OUR PRACTICE

1) ABOUT YOU			
Today's date: _____			
DOB: _____		AGE: _____	
Mr. Mrs. Ms.			
Name: _____			
Last	First	Mi	
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: _____		
Cell Ph#: _____		
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
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

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

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 Prosthesis 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 Rheumatoid Fever Y N Artificial Valves

Y N HIV+/AIDS Y N Heart surgery/Pacemaker

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 Severe/Freq. headaches

Y N Fever blister Y N Hi/Lo blood pressure

Y N Venereal disease Y N Drug/ Alcohol Abuse

Y N Ulcers/Colitis Y N Blood Transfusion

Y N Heart Murmur Y N Anemia/Radiation Tx

Y N Emphysema Y N Glaucoma

Y N Sinus Problems 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: _____