

PERSONAL INFORMATION – ADULT PATIENT

Date _____

Name _____ Mr./Mrs./Miss/Ms./Other _____ Sex _____
Last First Middle

Address _____
Street City State Zip Code

Dentist _____ Physician _____ Social Security No. _____

Date of Birth _____ Age _____ Phone _____

E-Mail Address: _____

Other Family Members Seen In Our Office: _____

Son(s) # _____ Age(s) () () () () Daughter(s) _____ Age(s) () () () ()

Married _____ Divorced _____ Widowed _____ Separated _____ Additional Comments _____

Employer _____ Occupation _____ Length of Emp. _____

Employer's Address _____ Business Phone No. _____

Spouse's Name _____ Social Security No. _____

Employer _____ Occupation _____ Length of Emp. _____

Employer's Address _____ Business Phone No. _____

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

In case we cannot reach you, person to contact _____ Phone No. _____

Insurance Coverage for Orthodontics? YES NO (If YES, please fill out last page)

For the following questions, circle YES or NO. The answers are for office records and will be considered CONFIDENTIAL. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

- Yes No Birth defects or hereditary problems?
- Yes No Bone fractures, any major accidents?
- Yes No Rheumatoid or arthritic conditions?
- Yes No Endocrine or thyroid problems?
- Yes No Kidney problems?
- Yes No Diabetes?
- Yes No Cancer or been treated for a tumor?
- Yes No Stomach ulcer or hyperacidity?
- Yes No Polio, mononucleosis, tuberculosis, pneumonia?
- Yes No Problems of the immune system?
- Yes No Hepatitis, jaundice or liver problem?
- Yes No AIDS or HIV positive?
- Yes No Sexually transmitted disease?
- Yes No Fainting spells, seizures, epilepsy or neurologic disease?
- Yes No Mental health or behavioral problems?
- Yes No Vision, hearing, tasting or speech difficulties?
- Yes No Loss of weight recently, poor appetite?
- Yes No Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
- Yes No High or low blood pressure?
- Yes No Tires easily?
- Yes No Chest pain, shortness of breath or swelling ankles?
- Yes No **Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints?**
- Yes No Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke?)
- Yes No Skin disorder?
- Yes No Do you have a normal and good diet?
- Yes No Frequent headaches, colds or sore throat?
- Yes No Eye, ear, nose, throat conditions?
- Yes No Hayfever, asthma, sinus trouble, hives?
- Yes No Tonsil or adenoid conditions?
- Yes No Allergies or drug reactions? _____
- Yes No Are you taking medication, nutrient supplements or nonprescription medicine?
Please name them _____
- Yes No Operations? (surgical procedures)?
- Yes No Hospitalized? For? _____
- Yes No Other physical problems or symptoms?
- Yes No Being treated by another health care professional? For? _____
- Date of most recent physical exam _____
- FEMALE PATIENTS**
- Yes No Are you pregnant?

DENTAL HISTORY

- Yes No Primary (baby) teeth removed that were not loose?
Yes No Permanent or "extra" (supernumerary) teeth removed?
Yes No Supernumerary (extra) or congenitally missing teeth?
Yes No Chipped or otherwise injured primary (baby) or permanent teeth?
Yes No Teeth sensitive to hot or cold; teeth throb or ache?
Yes No Jaw fractures, cysts, mouth infections?
Yes No "Dead Teeth", tooth canals treated?
Yes No Bleeding gums, bad breath, mouth odor?
Yes No Periodontal "Gum Problems"?
Yes No Food impaction between teeth?
Yes No "Gum Boils", frequent canker sores, cold sores?
Yes No Abnormal swallowing habit (tongue thrusting)?
Yes No History of speech problems?
Yes No Mouth breathing habit, snoring, difficulty in breathing?
Yes No Tooth grinding, jaw clenching, clicking, locking?
Yes No Any pain in jaw or ringing in the ears?
Yes No Do you experience any pain or soreness in the muscles of the face, or around the ears?

Yes No Difficulty encountered in chewing or jaw opening?
Yes No Aware of loose, broken or missing restorations (fillings)?
Yes No Any teeth irritating cheek, lip, tongue, palate?
Yes No Concerned about spaced, crooked, protruding teeth?
Yes No Aware or concerned about under or over developed jaw?
Yes No Any relative with similar tooth or jaw relationships?
Yes No Any wisdom tooth problems?
Yes No Have you had any serious trouble associated with any previous dental treatment?
Yes No Have you ever had a prior orthodontic examination or treatment?
Yes No Have you recently been under another dentist's care? Name _____
Yes No Have you ever had periodontal (gum) treatment?
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination _____

How often do you brush _____ Floss _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

Patient Signature

Date

PATIENT INSURANCE INFORMATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

INSURED PERSON: _____ DATE OF BIRTH: _____

INSURED PERSON'S SOCIAL SECURITY NUMBER: _____

PATIENT RELATIONSHIP TO INSURED: _____

INSURANCE COMPANY NAME & ADDRESS: _____

INSURANCE COMPANY PHONE NUMBER: _____

GROUP NUMBER: _____

EMPLOYER NAME & ADDRESS: _____

EMPLOYER PHONE NUMBER: _____

IS PATIENT COVERED BY ANOTHER PLAN? IF YES, FILL OUT BELOW

NAME OF INSURED: _____ DATE OF BIRTH: _____

INSURED PERSON'S SOCIAL SECURITY NO.: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

INSURANCE COMPANY PHONE NUMBER: _____

GROUP NUMBER: _____

EMPLOYER NAME & ADDRESS: _____

EMPLOYER PHONE NUMBER: _____