

Adult Patient Info

Date: _____

Name: _____ Nickname or name you prefer: _____
Last First MI

Title (Mr, Mrs, Ms, Dr, etc.): _____ Sex: M F Marital Status: Married Single Divorced Widowed

Birthdate: _____ Age: _____ Social Security: _____ Driver's License _____

Address: _____
Street City State Zip

How long at this address? _____ Email: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Best phone for reaching you during the day: Home Work Cell

Employer: _____ Occupation: _____ Years of employment: _____

Employer's address: _____
Street City State Zip

How did you hear about us? _____

GENERAL

Describe the primary concern with your teeth: _____

Y N Have you had any prior orthodontic consultation or treatment?

Insurance

Cardholder's name (if different from above): _____ Birthdate: _____
Last First MI

Relation to insured: _____

Insured Employee: _____

Insurance company name: _____

Insurance address: _____
Street City State Zip

Insurance phone: _____ Group name: _____

Insurance ID# or SS#: _____ Group ID#: _____

Secondary Insurance

Cardholder's name (if different from above): _____ Birthdate: _____
Last First MI

Relation to insured: _____

Insured Employee: _____

Insurance company name: _____

Insurance address: _____
Street City State Zip

Insurance phone: _____ Group name: _____

Insurance ID# or SS#: _____ Group ID#: _____

DENTAL

What is the reason for your visit today? _____

Date of last dental visit: _____ Last dental cleaning: _____ Last full mouth x-rays: _____

What was done at your last dental visit? _____

Previous Dentist's name: _____ Telephone: _____

Address: _____

How often do you have dental examinations?: _____

How often do you brush your teeth?: _____ How often do you floss?: _____

What other dental aids do you use? (Interplak, toothpick, etc.): _____

Y N Do you have any dental problems now? If yes, please describe: _____

Are any of your teeth sensitive to:

- Y N Hot or cold?
- Y N Sweets?
- Y N Biting or chewing?
- Y N Have you noticed any mouth odors or bad tastes?
- Y N Do you frequently get cold sores, blisters or any other oral lesions?
- Y N Do your gums bleed or hurt?
- Y N Have your parents experienced gum disease or tooth loss?
- Y N Have you noticed any loose teeth or change in your bite?
- Y N Does food tend to become caught between your teeth?
If yes, where? _____

Do you:

- Y N Clench or grind your teeth while awake or asleep?
- Y N Bite your lips or cheeks regularly?
- Y N Hold foreign objects in with your teeth? (pencils, pipe, pens, nails, etc.)
- Y N Mouth breathe while awake or asleep?
- Y N Have tired jaws, especially in the morning?
- Y N Smoke/chew tobacco?

Y N Is there anything else about having dental treatment that you would like us to know? If yes, please describe _____

Have you ever had:

- Y N Orthodontic treatment?
- Y N Oral surgery?
- Y N Periodontal treatment?
- Y N Your teeth ground or the bite adjusted?
- Y N A bite plate or mouth guard?
- Y N A serious injury to the mouth or head?
If yes, please describe, including cause _____

Have you experienced:

- Y N Clicking or popping of the jaw?
- Y N Pain? (joint, ear, side of face)
- Y N Difficulty in opening or closing the mouth?
- Y N Difficulty in chewing on either side of the mouth?
- Y N Headaches, neck aches or shoulder aches?
- Y N Sore muscles (neck, shoulders)?

Y N Are you satisfied with your teeth's appearance?

- Y N Would you like to keep all of your teeth all of your life?
- Y N Do you feel nervous about having dental treatment?
If yes, what is your biggest concern _____

Y N Have you ever had an upsetting dental experience?
If yes, please describe _____

MEDICAL

Y N Have you ever been under the care of a medical doctor during the past two years?

If yes, for what? _____

Current Medical Doctor: _____ Telephone: _____

Address: _____

Have you taken any medication or drugs over the past two years? _____

Y N Are you taking any medication, drug or pills now? _____

If yes, please list name and dosage: _____

Y N Have you ever taken prescription medications for weight loss (diet pills) If yes, did you take any of the following:

Y N Fen-Phen (Fenfluramine-Phenopermine) Y N Pondimen (Fenfluramine) Y N Redux (Deidenfluramine)

Y N Are you taking any medications for Osteoporosis? If yes, did you take any of the following?

Y N Bisphosphonates Y N Fosamax

Y N If yes, to any of the above, did you have a medical exam for heart issues?

Y N Are you aware of having an allergic (or adverse reaction) to any medication or substance?

If yes, please list: _____

Y N Have you been a patient in the hospital during the past five years?

Please indicate which of the follow you have had, or have presently.

Y N Heart (surgery, disease, attack) Y N Ulcers Y N Hepatitis A (infectious) B (serum)

Y N Chest pain Y N Diabetes Y N Venereal disease

Y N Congenial heart disease Y N Thyroid problems Y N A.I.D.S.

Y N Heart murmur Y N Glaucoma Y N H.I.V. positive

Y N High blood pressure Y N Contact lenses Y N Cold sores / fever blisters

Y N Mitral valve prolapse Y N Emphysema Y N Blood transfusion

Y N Artificial heart valve Y N Chronic cough Y N Hemophilia

Y N Heart pacemaker Y N Tuberculosis Y N Sickle cell disease

Y N Rheumatic fever Y N Asthma Y N Bruise easily

Y N Arthritis / Rheumatism Y N Hay Fever Y N Liver disease

Y N Cortisone medicine Y N Latex sensitivity Y N Yellow jaundice

Y N Swollen ankles Y N Allergies or hives Y N Neurological disorders

Y N Stroke Y N Sinus trouble Y N Epilepsy or seizures

Y N Diet (special / restricted) Y N Radiation therapy Y N Fainting or dizzy spells

Y N Artificial Joints (hip, knee, etc.) Y N Chemotherapy Y N Nervous / anxious

Y N Kidney trouble Y N Tumors Y N Psychiatric / Psychological care

Y N Do you use more than two pillows to sleep?

Y N Have you lost or gained more than 10 pounds in the past year?

Y N Do you have or have you had any disease, condition or problem not listed above?

If yes, please list: _____

Women Are you: Pregnant? Y, ____ Months N Nursing? Y N Taking birth control pills? Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health or medication.

Patient/Guardian Signature

Date