

## PATIENT INFORMATION-ADULT

Welcome to our office!

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, which is important for our records and your health, is confidential. Thank you.

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_  
FIRST MIDDLE LAST

Home Address \_\_\_\_\_ Home # \_\_\_\_\_  
STREET CITY ZIP CODE

Patient's Occupation or School \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Relationship \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_ E-Mail \_\_\_\_\_

Name of person to be contacted if patient cannot be reached:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

### Insurance

Is patient covered by insurance for orthodontic treatment? (Yes/No)

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Employer \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Insured Name \_\_\_\_\_ SS # \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship \_\_\_\_\_

### Family History

Marital Status \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Father Living? \_\_\_\_\_ Health \_\_\_\_\_ Mother Living? \_\_\_\_\_ Health \_\_\_\_\_

### Medical History

Height \_\_\_\_\_ Weight \_\_\_\_\_ Patient's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Has the patient ever had:

Asthma	Diabetes	Hearing Disorder	HIV
Anemia	Epilepsy	Heart Disease	Rheumatic Fever
Birth Defects	Endocrine Problems	Hepatitis	Other (describe below)
Blood Disease/Hemophilia	Emotional Problems	Herpes	
Bone Disorders	Head or Face Injury	High or Low Blood Pressure	

COMMENTS:

Has the patient been under the care of a physician during the past two years, other than for routine examination? Yes No

Condition: \_\_\_\_\_

Present drugs or medication: \_\_\_\_\_

Any allergies or reactions to any medication? \_\_\_\_\_

Any known allergies? (Yes/No) Specify: \_\_\_\_\_

Mouth breathing habit, snoring or difficulty in breathing? (Yes/No)

Have frequent colds, sore throat, or "stuffy nose"? (Yes/No)

Smoke (Yes/No) Any other tobacco products (Yes/No)

Has the patient received medical treatment from an allergist or ear, nose and throat specialist? (Yes/No)

Specify: \_\_\_\_\_

**Dental History**

Patient's Dentist \_\_\_\_\_ Date of last dental checkup \_\_\_\_\_

Were the patient's teeth cleaned? \_\_\_\_\_ Were full mouth or panoramic x-rays taken? \_\_\_\_\_

Does the patient have pain or clicking in jaw joint? (TMJ) (Yes/No)

Have any teeth been injured due to accidents or blows to the mouth? (Yes/No)

Has the patient had or been advised to have speech correction? (Yes/No)

Thumb, finger, or sucking habit? (Yes/No) Until what age? \_\_\_\_\_

Has the patient had any unusual dental experiences? (Yes/No) Specify: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Orthodontic History**

Has the patient had previous orthodontic consultation or treatment?      Yes      No

Date: \_\_\_\_\_ Dr: \_\_\_\_\_

Patient's interest in orthodontic treatment:      Wants Treatment      Treatment If Necessary      Unwilling But Agrees

What is the primary problem? \_\_\_\_\_

Additional comments you wish to make: \_\_\_\_\_

Signature of individual completing this form: \_\_\_\_\_ Date \_\_\_\_\_