FOR ADULTS: WELCOME TO OUR PRACTICE

1.) ABOUT YOU

Today's date: ________________ DOB: __________

Name: ______________________ AGE: __________

____

Last First MI (Mr. Mrs. Ms.)

I preferred to be called: _______________________

Home #: ______________________________________

Work #: ______________________________________

SS #: ____

DL #: ____

Home Address:

____

Apt#

____

City State Zip

Email: _______________________________________

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? ___________

3.) SPOUSE INFORMATION:

Name: _______________________________________

Employer: ____________________________________

WK#: ____

DL#: ____

SS#: ____

DOB: ____

DENTAL INFORMATION:

Previous/Present Dentist: ____________________

Street: _____________________________________

Phone: _____________________ **Last visit:** ________

4.) RESPONSIBLE PARTY INFO:

Name: _______________________________________

Billing address: _______________________________

____

City State Zip

WK#: Ext. HM#:

Employer: ____________________________________

DL #: ____

SS #: ____

Emergency Contact:

Name: _________________________ Relation: _______

Wk#: Ext. HM#

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

6.) DENTAL HISTORY

Why have you come to the orthodontist today? ____________________________

Are you currently in pain? Y N

You 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 physical 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 Weeks #: _______

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/Packmkr.
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 my 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: ____________________________