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Adult Patient Information

Patient's Name _____ _____ Today's Date _____

Birth Date____/_____/_____ Age_____ ❑M ❑F Email Address _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Cell Phone_____

Email Address: _____ ❑Single ❑Married❑Widowed ❑Divorced ❑Separated

Employer _____ Occupation _____ No. years employed _____

Social Security Number ____- ____-_____ Birth Date _____/_____/____Work Phone _____

Spouse's Name _____

Employer _____ Occupation _____ No. years employed _____

Social Security Number ____- ____-_____ Birth Date _____/_____/____Work Phone _____

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

COURTESY REMINDERS: ❑Text Number(s): _____ ❑Email :_____

Dental Insurance Information

Insured's Name _____ ____ Birth Date _____/_____/____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Phone No. _____

Do you have dual coverage? Yes _____ No: _____ If yes:

Insured's Name _____ Birth Date _____/_____/_____ SSN _____ - _____ - _____

Insurance Company _____Group No. _____ Phone _____

Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company. **Office Policy: Your Social Security Number will need to be on file should you decide to finance through our office.

Emergency Contact Information

Name of nearest relative *not* living with you _____Phone_____

Please continue to the back

Dental History

Are you interested in: (please indicate all that apply)

❑ Information ❑ Treatment now ❑ Clarification of previous or conflicting information

What is your chief concern? _____

1.	Have there been injuries to the face, mouth, or teeth?	❑ Yes ❑ No
2.	Do you have any speech problems?	❑ Yes ❑ No
3.	Have you been informed of any missing or extra permanent teeth?	❑ Yes ❑ No
4.	Has any previous orthodontic treatment been rendered?	❑ Yes ❑ No
5.	Do you suffer from any jaw joint problems such as pain, clicking, popping, etc.?	❑ Yes ❑ No
6.	Do you grind or clench your teeth during the day or night?	❑ Yes ❑ No
7.	Teeth difficult to clean?	❑ Yes ❑ No
8.	Awareness of any gum or bone problem around teeth?	❑ Yes ❑ No
9.	Concerned about the appearance of your teeth?	❑ Yes ❑ No

Other:_____

_____

Medical History

Name of your physician _____ Date of last exam_____

1. Is the patient in good health? ❑Yes ❑No
2. Does the patient have a health problem? ❑Yes ❑No If yes, explain_____
3. Does the patient have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc,)?

❑Yes ❑No If yes, please list: _____

4. Please list any current prescription medications: _____
5. Pregnant? ❑Yes ❑ No If so, Current trimester: _____
6. Has the patient been treated by a physician for any of the following conditions? (Check any that apply)

❑ Problems at Birth	❑ Hepatitis/Liver Disease	❑ Seizures
❑ Heart Disease/Murmur	❑ Tuberculosis	❑ Cleft Lip/Palate
❑ Rheumatic Fever	❑ Kidney Disease	❑ Speech or Hearing Problems
❑ Sickle Cell Anemia	❑ Cancer/Radiation Therapy	❑ Tonsil, Adenoid, Sinus Problems
❑ Anemia/Hemophilia	❑ Cerebral Palsy	❑ Emotional/Behavior Problems
❑ Diabetes	❑ Arthritis	❑ Learning Disabilities
❑ AIDS or HIV	❑ Asthma	❑ Growth Problems

Other:_____

_____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.

_____ _____

Responsible party signature Date