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 #:_____
DD #:_____
Home Address:
_____
Apt#
_____
City State Zip

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:_____
Cell Ph#:_____
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
Your 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 physician 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 Week #:_____
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/Pacmkr.
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 the 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:_____