Welcome

A B C

Adult Confidential Patient Information

Date ____________________

Patient's Name ____
First Middle Last

Address ____
Street City State Zip

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Hobbies/Interests ____________________ Birthdate ____________ ❑ Male ❑ Female

Whom may we thank for referring you to our office ____________ Nickname ____________

Dentist ____________________ E-mail Address ____________________

Confidential Billing Information

Name ______________________________________ Marital Status ____________
Mr., Ms., Mrs., Rev., Dr. First Initial Last

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

How long at this address ____________ Home Phone ____________ Work Phone ____________

Previous Address (if less than 3 yrs,) ____
Street City State Zip

Social Security # ______________________________ Birthdate ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Spouse's Name ____
Mr., Ms., Mrs., Rev., Dr. First Initial Last

Employer ____________ Occupation ____________ No. Years Employed ____________

Social Security# ____________ Birthdate ____________ Work Phone ____________

Dental Insurance Information

Policy Holder's Name ______________________________ Soc. Sec. # ____________
Relationship to patient

Policy Holder's Address if different from patient ____________________ Phone ____________

Insurance Company ____________ Group No. ____________ Union Local No. ____________

Insurance Co. Address ______________________________ Insurance Co. Phone ____________

Policy Holder's Employer ______________________________ **If dual coverage request a second insurance form.**

Emergency Information

Name of nearest relative not living with you ____

Complete Address ____

Phone ____________________ Relationship ____________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature ______________________________ Date ____________

Over ☛

What are your main orthodontic concerns? ______________________________

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Do you require antibiotic pre-medication for dental procedures?	❑ Yes	❑ No
Have you ever been evaluated for or had orthodontic treatment?	❑ Yes	❑ No
Have there been any injuries to the face, mouth, teeth or chin?	❑ Yes	❑ No
Have adenoids or tonsils been removed?	❑ Yes	❑ No
Have you been informed of any missing or extra permanent teeth?	❑ Yes	❑ No
Have you had any pain/tenderness in your jaw joint (TMJ/TMD)?	❑ Yes	❑ No
Do you floss your teeth daily?	❑ Yes	❑ No
Have you ever received or had recommended periodontal (gum) treatment?	❑ Yes	❑ No

Medical Information

Physician's Name ______________ Address ______________ Phone ______________

Date of last physical ____ / ____ / ____ Are you in good health? ❑ Yes ❑ No Are immunizations up to date? ❑ Yes ❑ No

Are you presently being treated for any condition? ❑ Yes ❑ No If so, explain ______________

Have you ever been diagnosed as having any of the following conditions? **Please circle "Y" for Yes or "N" for No**

Y N Abnormal Bleeding/Bruising	Y N Chronic Ear Infections	Y N Hepatitis or Liver Disease
Y N AIDS or HIV	Y N Congenital Heart Disease	Y N Hyperactivity/A.D.D.
Y N Allergies	Y N Convulsions or Seizures	Y N Kidney/Liver Disease
Y N Allergies to Drugs	Y N Diabetes	Y N Nutritional Deficiency
Y N Allergic to Latex/Metals	Y N Excessive Gagging	Y N Oral Ulcers
Y N Asthma	Y N Growth & Development Problems	Y N Rheumatic Fever
Y N Cancer	Y N Hearing/Speech Problems	Y N Tuberculosis
Y N Chronic Adenoid/Tonsil Infections	Y N Heart Murmur	Y N Other ______________
Y N Chronic Headaches	Y N Hemophilia	Y N Any Blood Transfusions?

Please discuss any medical problems that you have had ______________

____

Please list all drugs that you are currently taking ______________

Please list all drugs that you are allergic to ______________

Do you/did you have any of the following habits?

Clenching/Grinding Teeth	Y N	Mouth Breathing	Y N	Lip Sucking/Biting	Y N
Speech Problems	Y N	Thumb/Finger Sucking	Y N	Tongue Thrust	Y N
Nail Biting	Y N				

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.
I authorize the orthodontic staff to perform the necessary orthodontic services.

Signature ______________ Date ___ / ___ / ___

I verbally reviewed the medical/dental information with the patient named herein.

Initials ________ Date ___ / ___ / ___