

PATIENT INFORMATION – ADULT

ALL ABOUT YOU

Name: _____
Last First MI Mr Mrs Ms Dr
I prefer to be called: _____
Male: ___ Female: ___ Birthdate: ___/___/___ Age: ___
Single Married Divorced Widowed Separated
SS#: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home #: () _____ Cell #: () _____
Email: _____
Employer: _____ How long?: _____
Work #: () _____ Ext. _____
Work Address: _____
City: _____ State: _____ Zip: _____
Where/when is the best time to reach you?: _____
Whom may we thank for referring you?: _____
Emergency Contact: _____
Phone #: () _____

OTHER CONTACT INFORMATION

His/Her Name: _____
Relation: _____
Employer: _____
Phone #: () _____ Ext. _____

DENTAL HISTORY

General Dentist: _____
Date of Last Exam: _____
What are the main concerns that you would like orthodontics to accomplish?: _____

Have you ever had or been evaluated for orthodontic treatment? YES NO
Have you ever had a serious/difficult problem with any previous dental work? YES NO
Your current dental health is: GOOD FAIR POOR
Do you like your smile? YES NO
Do your gums ever bleed? YES NO
Have you ever had an injury to your: mouth/teeth/chin? YES NO
Do you have any missing or extra permanent teeth? YES NO
Do you generally breathe through your mouth? YES NO
If yes: While Awake? While Asleep?
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? YES NO

MEDICAL HISTORY

Your current medical condition is: GOOD FAIR POOR
Are you currently under the care of a physician?
 YES NO Please explain: _____
Physician's Name: _____
Are you taking any prescription/over-the-counter drugs?
 YES NO

Please list each one: _____

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Anemia/Radiation Treatment
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defects
Y N Diabetes
Y N Difficulty Breathing
Y N Drug or Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/ AIDS
Y N Hospitalization
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Shingles
Y N Sinus Problems
Y N Severe/Frequent Headaches
Y N Tuberculosis
Y N Ulcers/Colitis
Y N Venereal Diseases
Are you Pregnant? (Women) YES NO

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to the following?

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Latex Y N Tetracycline
Y N Dental Anesthetics Y N Metals/Plastics Y N Other

Please list any other drugs/materials that you are allergic to: _____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any necessary dental services that may be needed during diagnosis and treatment with my informed consent. Including obtaining x-rays and photographs.

Signature of parent or guardian _____ Date _____

Reviewed _____ Date _____

