

PATIENT INFORMATION – ADULT

Patient's Name _____ Title Mrs. Ms. Mr. Dr.
Date of Birth _____ Age _____ Sex Male Female Preferred Name _____
How did you hear about our office? _____
Relatives or friends previously treated here? _____
Address _____
Cell Phone Number _____ Email _____
Social Security # _____
Employer _____ Occupation _____
I am: Married Divorced Separated Single Widowed **Please fill the information below for Spouse/Other:**
Spouse / Other Name _____ Relationship to Patient _____
Date of Birth _____ Social Security # _____
Employer _____ Occupation _____
If anyone else besides you is Financially Responsible for your treatment, Name? _____

DENTAL INSURANCE INFORMATION

Dental Insurance Coverage? Yes No Orthodontic Insurance Coverage? Yes No Unsure
Insured's Name _____ Insured's Date of Birth _____
Insured's Social Security # _____ Insured's ID # _____
Insurance Company _____ Group # _____
Do you have dual coverage? Yes No **If yes, please fill the information below for the second insurance:**
Insured's Name _____ Insured's Date of Birth _____
Insured's Social Security # _____ Insured's ID # _____
Insurance Company _____ Group # _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Relationship to Patient _____
Address _____
Cell Phone _____ Email _____

Orthodontics is a service that provides an improvement in the appearance of the teeth (esthetics), in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate part of the body and may or may not respond well to treatment. If good oral hygiene is not practiced, problems such as tooth decay, enlarged and inflamed gums, and permanent marks on the teeth can result. Different amounts of risk exist in any medical or dental procedure, for example in orthodontics symptoms such as joint discomfort and root shortening are observed in a small percentage of cases. Whether or not there is any orthodontic treatment, teeth still may change and shift throughout our lifetime, and there can be some movement of teeth and some changes after treatment is over.

I have read and understand the above paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have read and understand the questions on this form and have accurately and truthfully answered all the above questions. I will not hold the doctor or any other staff member responsible for any errors or omissions that I have made in completing this form. I agree to inform this office of any changes in the patient's medical or dental history. In addition, I authorize the doctor to perform a complete orthodontic exam and take any diagnostic records (photos/x-rays) if necessary.

Signature_____
Print Name_____
Date

MEDICAL HISTORY

Physician Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Please mark (Yes) or (No) for the following questions about the Patient (If Yes, Please Fill in Details):

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Currently taking any medication ? List and reason for taking: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever taken a bisphosphonate ? (Fosamax, Boniva, Actonel, Zometa, Aredia, other) _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Need any Pre-Medication for Dental Procedures? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergy to any medication or Local Anesthetics (Novocaine or Lidocaine)? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergy to anything else? (Metals/ Nickel , Latex , Acrylic, plastic etc.) _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | History of a major illness? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Had any surgeries? Please explain: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been involved in a serious accident or had Bone Fractures? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has seen a physician in the last 12 months? Why? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Smoke, vape, chew or use any tobacco or marijuana products? _____ |

Female Patients Only: (this is to help the doctor determine patient's growth and maturation stage)

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has menstruation started? Approximately when? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is the patient pregnant? Expected Due Date? _____ |

Please mark any of the Medical Conditions below that the Patient has had in the past or currently has:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Jaw Pain/TMJ Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Kidney Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Mental Disorders (Anxiety, Depression) |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Nervous System/Neurological Disorders |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Family History of Underbite | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Defect (Congenital) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Pressure Problems (High or Low) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seasonal Allergies/Hay Fever |
| <input type="checkbox"/> Bone Disorders (Osteo- porosis or penia) | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Venereal Diseases |

***Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist or Pediatric Dentist Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

What concerns you most about your teeth? _____

Any preferred orthodontic option? Metal Braces Esthetic Metal Braces Clear Aligners (ex: Invisalign) No Preference

How soon do you want to get started? ASAP Within Weeks Within Months You tell me, Doc!

Is the Patient ... or Has the Patient ...

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitive or self-conscious about his/her teeth? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Excited to start orthodontic treatment? If not, why not? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever seen an orthodontist before? Who and when? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Had anyone in the family received orthodontic treatment? Who? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Currently in any dental pain? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Currently seeing another dental specialist? Who and why? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever experienced any unfavorable reaction to dentistry or specific treatment? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever lost, chipped, or damaged any teeth? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Had any teeth extracted previously (baby teeth, extra teeth etc.) _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had any injuries to face, mouth, or teeth? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Extra sensitive (to temperature or pressure) in any part of his/her mouth? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Noticed gum bleeding when brushing? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had any type of thumb/finger sucking or tongue thrusting habit? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had mouth breathing habit, snoring, or difficulty breathing? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had or needed Speech Therapy? When? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Experienced jaw clicking, popping, or TMJ pain? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had teeth or jaws ever feel uncomfortable first thing in the morning? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aware of clenching or grinding teeth? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Experienced "tension" headaches or chronic ringing in the ears (tinnitus)? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | In need of extra help with instructions? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you aware that some appointments will be during school/work hours? _____ |