



Adult History

Today's Date: _____

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

Name: _____ SS #: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female Birthdate: ____/____/____ Age: _____

Home Address: _____
APT / CONDO # CITY STATE ZIP

Hm #: _____ Wk #: _____ Cell #: _____ Email: _____

Single Married Divorced Widowed Separated

Employer: _____ How long there? _____

Employer's Address: _____

Occupation: _____ Where & when are best times to reach you? _____

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

Other family members seen by us: _____

General Dentist: _____ Last Visit Date: ____/____/____

Spouse's Name: _____ SS #: _____ Birthdate: ____/____/____

Employer: _____ Wk #: _____ Ext: _____

Person Responsible for Account: _____ SS #: _____
 (If different from above)

Billing Address: _____

Employer: _____

Relation: _____ Wk #: _____ Ext: _____ Hm #: _____

Cell #: _____ Email: _____

Orthodontic Insurance

Insurance Company: _____ Phone #: _____

Insurance Claims Address: _____

Subscriber ID #: _____ Group #: _____

Subscriber Name: _____ DOB: ____/____/____

Employer Name: _____

Medical History

Do you have a personal physician? Yes No Date of Last Visit: ____/____/____

Physician Name: _____ Phone #: _____

Your current physical health is: Good Fair Poor Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any prescription / over-the-counter drug? Yes No

Please list each one: _____

Are you pregnant? Yes No Week #: _____

(CONTINUED ON BACK)

Have you ever had any of the following diseases or medical problems?

(Please check all that apply)

- Allergic to Latex / Metals
- Anemia
- Asthma
- Cancer / Chemotherapy
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Emphysema
- Epilepsy / Seizures / Fainting Spells
- Heart Attack/Stroke
- Heart Murmur
- Heart Surgery / Pacemaker
- Hemophilia / Abnormal Bleeding
- Hepatitis
- High / Low Blood Pressure
- HIV + / AIDS
- Kidney Problems
- Mitral Valve Prolapse
- Scarlet Fever
- Severe / Frequent Headaches
- Sinus Problems

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

Please list any drugs that you are allergic to: _____

What are the main concerns that you would like orthodontics to accomplish or reason for seeking orthodontic treatment?

Have you ever been evaluated for orthodontic treatment? Yes No If yes, which Dr.? _____

Are you aware that patient cooperation is the main factor in length of orthodontic treatment and quality of result? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you need Pre-medication prior to dental visits? Yes No

Do you now or have you ever experienced pain / discomfort in you jaw joint (TMJ /TMD)? Yes No

Your current dental health is: Good Fair Poor Do you like your smile? Yes No

Do your gums bleed? Yes No Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you smoke? Yes No

Do you have any speech problems? _____

Do you generally breathe through your mouth: Yes No Awake? Yes No Asleep? (Please Circle)

Do you have any missing or extra permanent teeth? Yes No

- This office reserves the right to verify credit status of person responsible for the account and/or potential patients or parents of patients prior to extending credit for treatment fees.
- I understand that the information I have given today 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 changes in my medical status.



SIGNATURE

DATE

Our mission is to be recognized and respected for providing the highest quality orthodontic care with unrivaled customer oriented service.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use
Findings: _____ _____ _____
Recommendations: _____ _____ _____