SPECIALISTS IN ORTHODONTICS

CREATING GENERATIONS OF BEAUTIFUL SMILES

ADULT

PLEASE FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU.

ABOUT YOU

Today's Date: _____ Email Address: _____

Name: _____

Social Security #: _____ Date of Birth: _____

I prefer to be called: _____ ❑ Male ❑ Female ❑ Neutral

Home Address: _____

_____

City: _____ State: _____ Zip: _____

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Home #: ( ) _____ Cell #: ( ) _____

Work #: ( ) _____ Ext: _____ Other #: _____

Employer: _____

Employer's Address: _____

How long there: _____ Occupation: _____

When and where are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____ Last cleaning date: _____

SPOUSE/DOMESTIC PARTNER

Name: _____ ❑ Spouse ❑ Domestic Partner

Employer: _____

Cell #: ( ) _____

Work #: ( ) _____ Ext: _____ Other #: _____

Email Address: _____

SS #: _____ Birthdate: _____

PERSON RESPONSIBLE FOR ACCOUNT

❑ Self ❑ Spouse ❑ Domestic Parter ❑ Other _____

Home #: ( ) _____ Cell #: ( ) _____

Employer: _____

Work #: ( ) _____ Ext: _____ Other #: _____

Billing Address: _____

_____

City: _____ State: _____ Zip: _____

Relation: _____ SS #: _____

Employer: _____ Direct #: ( ) _____

ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, local or policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS#: _____

Insured's Employer: _____

SECONDARY

Orthodontic Coverage: ❑ Yes ❑ No Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, local or policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Home #: ( ) _____ Work #: ( ) _____

Cell #: _____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Best #: ( ) _____ Date of last visit: _____

Your current physical health is? ❑ Good ❑ Fair ❑ Poor

Are you currently under the active care of a physician? ❑ Yes ❑ No

Please explain: _____

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

_____

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

CONTINUED ON BACK

MEDICAL HISTORY (continued)

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

- ❑ Abnormal Bleeding
- ❑ ADHD/ADD
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones/Joints/Valves
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer/Chemotherapy
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug/Alcohol Abuse
- ❑ Emphysema
- ❑ Epilepsy/Seizures/Fainting
- ❑ Fever Blisters/Herpes
- ❑ Glaucoma
- ❑ Heart Attack/Stroke
- ❑ Heart Murmur
- ❑ Heart Surgery/Pacemaker
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV+/Aids
- ❑ Hospitalized for any reason
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Obstructive Sleep Apnea
- ❑ Osteoporosis
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Rheumatic/Scarlet Fever
- ❑ Severe/Frequent Headaches
- ❑ Shingles
- ❑ Sinus Problems
- ❑ Sleep Disorders
- ❑ Snoring
- ❑ Tuberculosis (TB)
- ❑ Ulcers/Colitis
- ❑ Venereal Disease

Please explain above or list serious medical condition(s) that you have ever had:
(Please use additional paper if needed) _____

_____

_____

Are you allergic to any of the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals/Plastics
- ❑ Tetracycline
- ❑ Penicillin
- ❑ Other

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

_____

_____

_____

Have you ever taken bisphosphonates? ❑ Yes ❑ No If yes, how long?_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to address?

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑ No

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

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

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like to smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your ❑ Mouth ❑ Teeth ❑ Chin ❑ Jaw

Do you have any missing or extra permanent teeth? ❑ Missing ❑ Extra ❑ No

Have your adenoids or tonsils been removed? ❑ Adenoids ❑ Tonsils ❑ No

HABITS/SLEEP CONDITIONS

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

- ❑ Clenching/Grinding Teeth
- ❑ Lip Sucking/Biting
- ❑ Mouth Breather ❑ While awake ❑ While asleep?
- ❑ Nail Biting
- ❑ Speech Problems _____

Sleep Position: ❑ Side ❑ Back ❑ Stomach ❑ Varies

Is it easy to fall asleep? ❑ Yes ❑ No

Do you feel rested upon awaking? ❑ Yes ❑ No

Do you stop breathing during sleep? ❑ Yes ❑ No

Have you ever had a sleep study (PSG)? ❑ Yes ❑ No Result was?_____

Average hours of sleep per night?_____

Do you wake often during the night? ❑ Yes ❑ No

Gasping during sleep? ❑ Yes ❑ No

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

_____
Signature **Date**

As this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I understand that the information that 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature **Date**

I _____ Have received a copy of this office's *Notice of Privacy Practices*.

_____
Signature **Date**

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

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____ Date: _____

_____

_____