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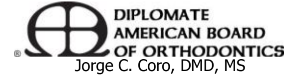

Adult History

We would like to welcome you to our office. Our goal is to make your visit pleasant and educational.

Please fill out the information below:

Today's Date: ________________________ ****Confirmation preference – Text ☐ Email ☐** ____________________________

Patient Name:	SS #:	☐ Male ☐ Female
Birthdate: Age: Home #:	Other #:	Email:
Home Address:	How long at present address:	☐ Own ☐ Rent
Previous Address (if less than 3 years):		
Billing Address (if different):		
Whom may we thank for referring you to our office?		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
Employer:	How long at current job:	Job Title:
Work #: Ext:	Cell #:	Email:
Spouse's Name:	SS #:	
Employer:	How long at current job:	Job Title:
Work #: Ext:	Cell #:	Email:
Person Responsible for the Account: (if different from above)		
Name:		SS #:
Home Address:	How long at present address:	☐ Own ☐ Rent
Previous Address (if less than 3 years)		
Billing Address (if different):		
Employer:	How long at current job:	Job Title:
Relationship to Patient:	Home #:	Work #:
Emergency Information:		
Name of nearest relative not living with you:		
Relationship:	Phone #:	Other #:

I realize it may be appropriate to utilize a credit report in determining a payment plan.

Signature: ____ Date: ______________________

Orthodontic Insurance

Name of Insurance Company:	Phone #:	
Insurance Address:	City/State/Zip:	
Subscriber Name:	DOB:	
Employer Name:	Subscriber ID #:	Group #:

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Dental History

Dentist Name: ______________________________________ Last Dental Visit: ____/____/_____ Check-up Frequency: ______________

Has patient had an orthodontic consult or treatment? Yes ☐ No ☐ If so, when? ________________________________

What is the patient's main orthodontic concern? ____

Speech problems/Therapy?	Yes ☐ No ☐	Brush teeth daily?	Yes ☐ No ☐
Grind or clench teeth?	Yes ☐ No ☐	Floss teeth daily?	Yes ☐ No ☐
Oral habits (thumb/finger habit, lip/nail biting)?	Yes ☐ No ☐	Fluoride treatments?	Yes ☐ No ☐
Injury to face, jaw, teeth or mouth?	Yes ☐ No ☐	Mouth breathing?	Yes ☐ No ☐
Discomfort from teeth or gums?	Yes ☐ No ☐	Snores during sleep?	Yes ☐ No ☐
Pain, tenderness or noise in either jaw?	Yes ☐ No ☐	Requires premedication?	Yes ☐ No ☐
Frequent headaches?	Yes ☐ No ☐	Any missing or extra permanent teeth?	Yes ☐ No ☐
Neck/Shoulder pain?	Yes ☐ No ☐	Apprehensive about dental care?	Yes ☐ No ☐
Frequent sore throats?	Yes ☐ No ☐	Frequently chews gum?	Yes ☐ No ☐

Comments:

____

Medical History

Physician Name: ____ Date of last Visit: _____/_____/______

Address: ____ City/State/Zip: ______________________ Phone: ____________________

List any medications currently being taken by the patient: ____

List any drug allergies or sensitivities that the patient may have: ____

Rheumatic Fever	Yes ☐	No ☐	Growth Problems	Yes ☐	No ☐
Tuberculosis/Lung Disease	Yes ☐	No ☐	Hormone Therapy	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐	Endocrine Problems	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Latex Allergy	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Jewelry / Metal Allergy	Yes ☐	No ☐
Heart Attack/Stroke	Yes ☐	No ☐	Nervous Disorders	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Hyperactivity	Yes ☐	No ☐
Congenital Heart Defect	Yes ☐	No ☐	Bone Disorders/Osteoporosis	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Hemophilia	Yes ☐	No ☐	Mononucleosis	Yes ☐	No ☐
Hypertension/High Blood Pressure	Yes ☐	No ☐	Seizures/Epilepsy	Yes ☐	No ☐
Prolonged Bleeding/Transfusion	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
HIV/AIDS	Yes ☐	No ☐	Fainting/Dizziness	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Handicaps/Disabilities	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Treated for Emotional Problems	Yes ☐	No ☐
Family History of Cancer	Yes ☐	No ☐	Tonsils Removed	Yes ☐	No ☐
Received Radiation Treatment	Yes ☐	No ☐	Adenoids Removed	Yes ☐	No ☐
Ever Been Hospitalized	Yes ☐	No ☐	Other	Yes ☐	No ☐

If any of the above questions were answered "Yes", please explain: ____

____

Signature: ____ **Date:** __________________________