Adult Patient Information

The benefits of a happy, healthy Smile are immeasurable
Our goal is to make everyone's visit pleasant and educational.
Please fill out the information below

Today's Date_____

Name _____ SS # _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called _____ Birth date_____ Age_____ ☐ Male ☐ Female

Home address_____
Street Apt/Condo # City State Zip Code

E-mail _____ Home #_____ Alternate # _____

Employer _____ Phone #_____ How long there _____

Employer's address_____
Street City State Zip Code

Occupation _____ Where/when are the best times to reach you? _____

Whom may we thank for referring you_____

Please list your other family members seen by us _____

General dentist_____ Date of last visit _____

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name_____SS#_____Birth date_____

E-mail_____Employer _____ Work #_____

Person Responsible for Account _____SS#_____

Home #_____Relationship_____

Billing address_____
Street Apt/Condo# City State Zip Code

Previous address_____
Street Apt/Condo# City State Zip Code

Primary Dental Insurance Do you have orthodontic coverage? ☐ Yes ☐ No

Insurance Co. Name_____

Insurance Co. Phone #_____ID #_____Group #_____

Policy Owner's Name _____Birth date_____ SS #_____

Policy Owner's Relation _____Employer_____

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Secondary Dental Insurance Do you have orthodontic coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Phone # _____ ID # _____ Group # _____

Policy Owner's Name _____ Birth date _____ SS # _____

Policy Owner's Relation _____ Employer _____

Health History

What are the main concerns that you would like the orthodontist to address _____

_____

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

Have there been any injuries to the face, mouth, teeth or chin? ☐ 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

Do you like your smile? ☐ Yes ☐ No Do your gums bleed? ☐ Yes ☐ No

Please describe your current dental health ☐ Good ☐ Fair ☐ Poor

For women: Are you Pregnant ☐ Yes ☐ No Week #_____ Are you nursing ☐ Yes ☐ No

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

☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Heart attack/stroke	☐ Yes ☐ No	High/low blood pressure
☐ Yes ☐ No	Difficulty breathing	☐ Yes ☐ No	Cancer/chemotherapy	☐ Yes ☐ No	Heart surgery/pacemaker
☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No	Congenital heat defect	☐ Yes ☐ No	Hemophilia/abnormal bleeding
☐ Yes ☐ No	Asthma/arthritis	☐ Yes ☐ No	Kidney/liver problems	☐ Yes ☐ No	Seizures/epilepsy/fainting
☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No	Allergic to latex/metals	☐ Yes ☐ No	Anemia/radiation treatment
☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Allergies to any drugs	☐ Yes ☐ No	Rheumatic/scarlet fever
☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Emphysema/glaucoma	☐ Yes ☐ No	Diabetes/Tuberculosis (TB)

Please list any serious medical conditions that you have _____

Physician name _____ Phone # _____

Date of last visit _____ Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

Please describe your current physical health ☐ Good ☐ Fair ☐ Poor

Please list any prescription/over the counter drugs you are taking _____

Please list any drugs/materials/foods/flavorings (mint, cinnamon, etc.) that you are allergic to _____

_____

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Doctor's comments _____

_____

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TMJ History

Name: _____

Today's Date: _____

☐ Yes ☐ No Do you have difficulty and/or pain opening your mouth for instance, when yawning?

☐ Yes ☐ No Does your jaw get "stuck", "locked" or "go out"?

☐ Yes ☐ No Do you have difficulty and/or pain when chewing, talking or using your jaw?

☐ Yes ☐ No Are you aware of noises in the jaw joints?

☐ Yes ☐ No Do you have pain in or about the ears, temples or cheeks?

☐ Yes ☐ No Does your bite feel uncomfortable or unusual?

☐ Yes ☐ No Do you have frequent headaches?

☐ Yes ☐ No Have you had a recent injury to your head, neck or jaw?

☐ Yes ☐ No Have you previously been treated for a jaw joint problem?