

Adult Patient Information

Patient's Name _____ Today's Date _____
 Birth Date ____/____/____ Age _____ M F Email address: _____
 Mailing Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Employer _____ Occupation _____ Years Employed _____
 Dentist _____ Date of Last Dental Check Up _____
 Whom may we thank for referring you to our office? _____

Responsible Party Information

Self Spouse Other Name _____ Single Married Divorced Separated
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security Number _____ - _____ - _____ Birth Date ____/____/____ Relationship to Patient _____
 Employer _____ Occupation _____ Years Employed _____

Insurance Information

Policy Holder's Name _____ Birth Date ____/____/____ SSN _____ - _____ - _____
 Insurance Company _____ ID No. _____ Group No. _____
 Insurance Co Address _____ City _____ State _____ Zip _____
 Phone _____
2nd Insured's Name _____ Birth Date ____/____/____ SSN _____ - _____ - _____
 Insurance Company _____ ID No. _____ Group No. _____
 Insurance Co Address _____ City _____ State _____ Zip _____
 Phone _____

Please Note: We call to check on orthodontic benefits as a courtesy to our patients, this is not a guarantee of benefits. If you wish to proceed with orthodontic treatment we will gladly work with your insurance company.

Emergency Contact Information

Name of nearest relative not living with you: _____ Phone: _____

Dental History

What is your main concern? _____

Are you interested in: (Please indicate all that apply)

Information Treatment now Clarification of previous or conflicting information

1. Have there been injuries to the face, mouth, or teeth? Yes No
2. Do you have any speech problems? Yes No
3. Have you been informed of any missing or extra permanent teeth? Yes No
4. Has any previous orthodontic treatment been rendered? Yes No
5. Do you suffer from any jaw joint problems such as pain, clicking, popping, etc.? Yes No
6. Do you grind or clench your teeth during the day or night? Yes No
7. Teeth difficult to clean? Yes No
8. Awareness of any gum or bone problem around teeth? Yes No
9. Concerned about the appearance of your teeth? Yes No

Other: _____

Medical History

Name of your physician _____ Date of last exam _____

1. Are you in good health? Yes No
2. Do you have a health problem? Yes No If yes, explain _____
3. Do you have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc.)?
 Yes No If yes, please list: _____
4. Please list current prescription medications you are taking: _____
5. Have you been treated by a physician for any of the following conditions? (Check any that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Problems at Birth | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease/Murmur | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cleft Lip/Palate |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Speech or Hearing Problems |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Cancer/Radiation Therapy | <input type="checkbox"/> Tonsil, Adenoid, Sinus Problems |
| <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Emotional/Behavior Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> Growth Problems |

Other: _____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any *changes*. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.

_____ Responsible party signature

_____ Date

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