

*WELCOME TO OUR OFFICE!*

Please thoroughly complete both pages of this form – Thank You!

Adult Patient Information

Patient's Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

e-mail address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Person\* Responsible for Account:  Myself  Other \_\_\_\_\_ Relationship \_\_\_\_\_  
(\*This person must sign permission to treat forms )

S.S. # \_\_\_\_\_ Driver's License # & State issued \_\_\_\_\_

Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Address: \_\_\_\_\_

Did your dentist refer you to our office?  Yes  No; If no, who did? \_\_\_\_\_

Do you have a: **LATEX ALLERGY?**  Yes  No

**HEART MURMUR?**  Yes  No If YES, do you require Pre-Medication?  Yes  No

If YES, we need to contact the physician who monitors this health issue. Name & address:

Who noticed your orthodontic concern?  Myself  Dentist  other \_\_\_\_\_

Dr. Sanford would appreciate it if you would describe your orthodontic concern in your own words: \_\_\_\_\_

What concerns you most about the thought of orthodontic treatment?  my appearance in appliances  cost

length of time in appliances  discomfort  results  other \_\_\_\_\_

What are some of your interests or hobbies? \_\_\_\_\_

Family Information

Spouse's Name \_\_\_\_\_ Do you have children?  Yes  No

If yes, what are their names & birthdates? \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Wk Phone \_\_\_\_\_

In case of emergency, person to be notified & phone number: \_\_\_\_\_



*OFFICE USE: Pre-Med letter sent on \_\_\_\_\_ Response Received  Yes  No Chart Labeled*

*Yes*