WELCOME TO OUR OFFICE!

Please complete both pages of this form – Thank You!

Adult Patient Information

Patient's Name: _____ Prefer to be called:_____

Date of Birth: _____ Sex_____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____

Person* Responsible for Account:
□Myself □Other_____Relationship_____
(*This person must sign permission to treat forms)

S.S. # _____ Driver's License # & State issued _____

Occupation_____ Employer: _____

General Dentist: _____ Address:_____

Did your dentist refer you to our office? □Yes □No If no, who referred you? _____

Do you have a: Latex allergy □Yes □No

Heart murmur? □Yes □No If YES, do you require Pre-Medication? □Yes □No

If YES, which physician monitors this health issue?

Name & address: _____

Who noticed your orthodontic issues? □Myself □Dentist □ Other

Please describe your orthodontic concerns in your own words: _____

_____

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

□ length of time in appliances □ discomfort □ results □ other _____

Family Information

Spouse's Name_____ Do you have children? □Yes □No

If yes, what are their names & birthdates?

_____

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

_____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept confidential.

MEDICAL HISTORY

Physician_____**Address**_____**Phone**_____

Have you experienced any health problems? ☐**No** ☐**Yes** **Explain** _____

Any major change in your health recently? ☐**No** ☐**Yes** **Explain** _____

Are you currently under physician's care? ☐**No** ☐**Yes** **Explain** _____

Are you currently taking medications? ☐**No** ☐**Yes** **List** _____

Are you allergic to any medications? ☐**No** ☐**Yes** **List** _____

Have you received a blood transfusion? ☐**No** ☐**Yes** **Reason**_____

Have your tonsils or adenoids been removed? ☐**No** ☐**Yes** **When**_____

Have you been in a risk group for AIDS? ☐**No** ☐**Yes** **Explain**_____

Have you had any of the following conditions?:

Heart Surgery…… □No □Yes Hepatitis…….. □No □Yes Emotional Difficulties… □No □Yes Anemia … □No □Yes
Rheumatic Fever….. □No □Yes Diabetes…….. □No □Yes Frequent Headaches……□No □Yes Bronchitis…□No □Yes
Endocrine Disorders □No □Yes Kidney Disease…….□No □Yes Nervous/Anxious…….. □No □Yes Tonsillitis….□No □Yes
Prolonged Bleeding… □No □Yes Liver Disease…. □No □Yes Cancer…….. □No □Yes Asthma…... □No □Yes
Bone Disorders…… □No □Yes Tuberculosis……. □No □Yes Hives/Rash…….. □No □Yes Epilepsy… □No □Yes
Growth Disorders…… □No □Yes Mouth Breather… □No □Yes, When? Awake _____ Asleep _____
Development Disorder…□No □Yes Herpes Simplex/Fever Blisters ……□No □Yes Fainting ……□No □Yes

Is there any other condition or problem that you think we should know about? _____

DENTAL HISTORY

Are you under a Dental Specialist's care? ☐**No** ☐**Yes, Specialist's Name, Address, & Reason for Treatment:**_____

_____

Frequency of dental checkups: ☐**Twice a Year** ☐**Once a Year** ☐**Only if a problem occurs** ☐**Never** **Date of last visit**_____

Is there any unfinished care to be completed by your dentist? ☐**No** ☐**Yes, Explain** _____

Are you frightened about dental treatment? ☐**No** ☐**Yes, Explain** _____

Any previous unpleasant dental experiences? ☐**No** ☐**Yes, Explain** _____

Have you had any face or dental injuries? ☐**No** ☐**Yes, Explain** _____

Do you play any musical instruments? ☐**No** ☐**Yes, What instrument?**_____

Have you consulted another orthodontist or had previous ortho treatment? ☐**No** ☐**Yes, with whom?** _____

Are you satisfied with prior treatment? ☐**No** ☐**Yes** **Any Comment?** _____

Have teeth (either primary or permanent) been removed? ☐**No** ☐**Yes** **Explain**_____

Have you noticed any changes in your bite or dental alignment recently? ☐**No** ☐**Yes** **Explain**_____

What are your chief concerns regarding the position of your teeth or bite: ☐Appearance ☐Cleaning ☐Comfort ☐Ability to chew ☐Stability ☐Function Please elaborate _____

What concerns has your dentist expressed relating to your bite or alignment: ☐Wear or fractures of teeth ☐Bone or gum tissue loss ☐Difficulty with cleaning related to tooth alignment ☐Jaw joint or muscle tightness or discomfort ☐Alignment of teeth prior to restorative dental work (crown, bridges, etc.) ☐other Please elaborate _____

Please check if there is a history of:

□ Clenching teeth □ Muscular Soreness around head & neck □ Jaw joint soreness □ Jaw joint popping □ Jaw joint clicking
□ Grinding teeth □ Headaches (more than normal) □ Ringing in the ears □Speech Problems w/sounds:_____

Is there any other information that may be helpful?_____

_____ _____ _____

Patient's Signature **Date** **Reviewed by**