WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information - Adult

Patient Name (First, Middle, Last) _____ Age _____ Birth Date_____

Nickname (if preferred) _____ Check One: ____ Male ____ Female

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ SS# _____

Home Address (Street) _____ City, State, ZIP _____

Employer_____ Employer's Address _____

Occupation _____ How long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? (Check one): ____YES ____NO If YES, Name _____

Have you visited an orthodontist before? (Check one): ____YES ____NO If YES, for what reason? _____

Anything you would like to discuss with the doctor in private? (Check one): ____YES ____NO

Email _____

Insurance Information

Marital Status (Check one): Single _____ Married _____ Widowed _____ Divorced _____ Domestic Partner _____

Primary

Insurance Company Name _____ Insurance Company Phone (_____)_____-_____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS# _____

Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name _____ Insurance Company Phone (_____)_____-_____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS# _____

Insured's Employer _____ Employer's Address _____

HEALTH HISTORY (please check if patient has condition or received treatment)

- ☐ ADD/ADHD/Behavioral issues
- ☐ AIDS/HIV Infection
- ☐ Allergies (please list):
  _____
  _____
  _____
- ☐ High/Low Blood Pressure
- ☐ Artificial Joints Valves/Fever/Disease
- ☐ Seizures/Strokes/Epilepsy
- ☐ Cancer/Tumors
- ☐ Blood Disorder/Anemia
- ☐ Cold Sores
- ☐ Diabetes or Hypoglycemia
- ☐ Emotional Disturbances
- ☐ Endocrine Problems
- ☐ Eye/Hearing/Speech Impairment
- ☐ Handicapped/Disabilities
- ☐ Herpes
- ☐ Heart Condition/Angina Murmur/Chest Pain
- ☐ Arthritis
- ☐ Radiation Therapy
- ☐ Hepatitis A, B, or C
- ☐ Bone Disorder/ Bisphosphonates
- ☐ Tuberculosis
- ☐ Rheumatic
- ☐ Autism

Other Condition(s) not listed _____
List any medication _____
Are you under the care of a physician at the current time, list reason _____
History of major illness? If YES, please describe _____
Currently taking medication? If YES, please list _____ Amount/Dose _____
Are you pregnant? _____
Family Physician _____ Phone (_____)_____-_____ Date of Last Visit _____

DENTAL HISTORY (please check if patient has condition or received treatment)

- ☐ Injury to face, mouth, or teeth
- ☐ Thumb, finger, or lip sucking habit
- ☐ Mouth breathing, asleep or awake
- ☐ Tongue thrust
- ☐ Removed tonsils
  Date of Removal _____
- ☐ Any known missing permanent teeth
- ☐ Any known extra permanent teeth
- ☐ Teeth removed by extraction, Date: _____
- ☐ Musical Instrument _____
- ☐ Clenching/Grinding of teeth
  List Day, Night, or Both _____
- ☐ Frequent Headaches
- ☐ Adenoids Removed, Date of Removal:
  _____
- ☐ Pain when popping, locking on opening or closing jaw movement
- ☐ Muscle tenderness or stiffness in jaw or neck area
- ☐ Dizziness or ringing in ear
- ☐ Snoring or breathing heavily when sleeping
- ☐ Previous treatment of TMJ problems

Signature

I understand that the information that I have provided 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. I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____ Date _____