

Adult Patient Information

Date _____

Patient's Name _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SSN _____ DOB ____/____/____ Age _____ Sex _____

Employer _____ Occupation _____ How Long? _____

Spouse _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ How Long? _____

General Dentist _____ City _____ State _____ Zip _____

How did you hear about our office? _____

Are you financially responsible for this account? _____

This office reserves the right to verify the credit status of potential patients seeking payment terms prior to extending credit for treatment fees and may use the services of one or more credit reporting agencies.

Signature _____ **Date** _____

Orthodontic Insurance Information

Insured's Name _____ DOB ____/____/____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Phone _____

Do you have dual coverage? Yes No

2nd Insured's Name _____ DOB ____/____/____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Phone _____

Emergency Information

Name of Contact Person _____ Relationship _____

Daytime Phone: _____

Medical History

Are you in good health? _____ Yes No

Physician's Name _____ City _____

Do you have a history of major illness? _____ Yes No

Have you ever been under the care of a physician for a major illness? _____ Yes No

If so, circle which of the following you have been treated for:

ARTHRITIS	DIABETES	HEART PROBLEMS	RHEUMATIC FEVER
ASTHMA	EPILEPSY	HEPATITIS	SINUS PROBLEMS
BLOOD DISORDER	FAINTING/DIZZINESS	HERPES	TUBERCULOSIS
CANCER	GLAUCOMA	HIV+/AIDS	VENEREAL DISEASE
COLD SORES	HEARING LOSS	KIDNEY/LIVER	OTHER

Are you now, or could you be pregnant? _____ Yes No

Have tonsils and adenoids been removed? What age? _____ Yes No

List any drugs or medications now being taken. _____

Please give reason. _____

Are you taking any medication for osteoporosis? If so, what and for how long? _____

List any allergies or sensitivities: (drug, latex, metal, plastic, other) _____

Dental History

Have there been injuries to the face, mouth, or teeth? _____ Yes No

Have you ever sucked your thumb or finger? Until what age? _____ Yes No

Do you have any speech problems? _____ Yes No

Do you have a tongue thrust? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ___ Yes No

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH? _____

Are you interested in **invisalign®** as a treatment option? _____

I understand that the information that 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.

I authorize the dental staff to perform the necessary dental services I may need.

Signature _____ **Date** _____