

Adult Form

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Orthodontic Specialists

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A B C

Report Date: _____

EXAM

Month	Day	Year

Dr. _____

Recs. _____
Date Time

X-Ray _____
Date Time

1 | Tell us about yourself

Name _____
Last First Middle Preferred Name

Male Female Birth Date: _____ Age: _____

Address: _____
City Zip How long at this Address: _____

Home Phone: (____) _____ E-mail: _____

Family in treatment with us: _____

Whom may we thank for referring you? _____

2 | General Dentist: _____ Last visit date: _____

Address: _____ Phone #: (____) _____

3 | Employer Information

Employer: _____ Job Title: _____

Work Phone #: (____) _____ Fax or cell #: (____) _____

How long at current job: _____ SS#: _____ DL#: _____

4 | Marital Status Single Married Widowed Divorced Separated

Person (NOT living with you) to contact in case of emergency:

Name: _____ Relationship: _____ Phone #: (____) _____

5 | Spouse Information

Name _____ Birth Date: _____

Employer: _____ Work Phone #: (____) _____ Work Fax #: (____) _____

How long at current job: _____ SS#: _____ DL#: _____

6 | Primary Orthodontic Insurance

Insurance Co. name: _____

Policy owner's name: _____

Policy owner's birthdate: _____

Policy owner's SS#: _____

7 | Secondary Orthodontic Insurance

Insurance Co. name: _____

Policy owner's name: _____

Policy owner's birthdate: _____

Policy owner's SS#: _____

8 | Dental History

Any injuries to head or mouth? _____ Any jaw clicking, locking or pain? _____

Have you ever had orthodontic treatment? **Y** or **N** When: _____ Name of orthodontist: _____

Have your Wisdom Teeth been removed? **Y** or **N** When: _____ Name of oral surgeon: _____

What is your main concern? _____

Please check YES or NO to any of the following conditions that apply to you:

- | | | |
|--|---|--|
| Y N (please check) | Y N (please check) | Y N (please check) |
| <input type="checkbox"/> <input type="checkbox"/> Bad Breath | <input type="checkbox"/> <input type="checkbox"/> Frequent Cold Sores, Canker Sores | <input type="checkbox"/> <input type="checkbox"/> Periodontal Problems / Pockets |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> <input type="checkbox"/> Grinding Teeth or Clenching | <input type="checkbox"/> <input type="checkbox"/> Root Canals |
| <input type="checkbox"/> <input type="checkbox"/> Chipped / Injured Teeth | <input type="checkbox"/> <input type="checkbox"/> Jaw Fractures | <input type="checkbox"/> <input type="checkbox"/> Sensitivity to Cold / Heat |
| <input type="checkbox"/> <input type="checkbox"/> Cyst / Infection | <input type="checkbox"/> <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> <input type="checkbox"/> Teeth Irritating Cheek / Lips |
| <input type="checkbox"/> <input type="checkbox"/> Dental Treatment in Progress | <input type="checkbox"/> <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> <input type="checkbox"/> Thumb Habit To Age _____ |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing / Chewing | <input type="checkbox"/> <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> <input type="checkbox"/> Tongue Habit, Swallowing Problems |
| <input type="checkbox"/> <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> <input type="checkbox"/> Nail Biting | <input type="checkbox"/> <input type="checkbox"/> Any Permanent or Extra Teeth Removal |

9 | Medical History

Physician _____ Phone #: _____ Last visit: _____

Please list all medications you are currently taking (or have taken in the past 2 years): _____

Are there any psychological or emotional problems that should be brought to our attention: _____

Do you need to be pre-medicated: **Y** or **N** Why: _____

(Females) Are you: Taking birth control pills? **Y** or **N** Pregnant?: **Y** or **N** Nursing?: **Y** or **N**

Allergies: _____ Medical Insurance: _____
(Foods / Medications / Latex Gloves / Unknown ...)

Have you ever been hospitalized? **Y** or **N** Explain: _____

Please check YES or NO to any of the following conditions that apply to you:

- | | | | |
|---|---|--|--|
| Y N (please check) | Y N (please check) | Y N (please check) | Y N (please check) |
| <input type="checkbox"/> <input type="checkbox"/> Accidents | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> <input type="checkbox"/> Rehabilitation Drugs/Alcohol | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Diabetes / Blood Sugar | <input type="checkbox"/> <input type="checkbox"/> HIV Positive / AIDS | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> <input type="checkbox"/> Severe Infections |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Fainting-Seizures-Convulsions | <input type="checkbox"/> <input type="checkbox"/> Kidney or Bladder | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Glandular/Hormonal Problems | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Speech / Learning Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Autism | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems | <input type="checkbox"/> <input type="checkbox"/> Headaches - Migraines | <input type="checkbox"/> <input type="checkbox"/> Mono | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> <input type="checkbox"/> Nervous / Hyperactive | <input type="checkbox"/> <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> <input type="checkbox"/> Bruises Easily | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Pneumonia | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency | Describe: _____ | <input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |

10 | Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that, if necessary, credit bureau reports may be obtained.

It is my responsibility to advise the office of any changes in personal/medical status: _____ Initials _____

Please sign that this information is accurate and complete:

Signature _____ Date _____

Received by Dr. _____ Date _____

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps or problems we might encounter? **Y** or **N**