

ADULT FORM

Please take this time to tell us about yourself

Today's Date: May 17, 2011

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

E mail Address: \_\_\_\_\_

Birth date: \_\_\_\_\_

SS#: \_\_\_\_\_  Male  Female

Single  Married  Divorced  Widowed

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext \_\_\_\_\_

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

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

Kids (List names, ages and birthdays):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who may we thank for referring you to our office?  
\_\_\_\_\_

DENTIST INFORMATION

Dentist Name: \_\_\_\_\_

Dentist Phone #: \_\_\_\_\_

Last Dental Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

INSURANCE

**PRIMARY DENTAL INSURANCE**

Orthodontic Coverage?  Yes  No

Lifetime Maximum? \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: \_\_\_\_\_

ID #: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Insured's Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: \_\_\_\_\_

ID #: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Insured's Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

SPOUSE INFORMATION

His/Her Name: \_\_\_\_\_

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

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

Work #: \_\_\_\_\_ Ext \_\_\_\_\_

SS#: \_\_\_\_\_

Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

EMERGENCY CONTACT

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

MEDICAL HISTORY

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you taking any prescription medication?  Yes  No

If so, which ones? \_\_\_\_\_

For Women: Are you pregnant?  Yes  No

Have you ever had any of the following diseases or medical problems?

Abnormal bleeding  Yes  No Dizziness  Yes  No

Diabetes  Yes  No Endocrine  Yes  No

Lung  Yes  No Arthritis  Yes  No

Anemia  Yes  No Epilepsy  Yes  No

Herpes  Yes  No Heart Murmur  Yes  No

HIV / Aids  Yes  No Rheumatic Fever  Yes  No

Bone Disorders  Yes  No Heart Problems  Yes  No

Kidney problems  Yes  No Tuberculosis  Yes  No

Nervous Disorders  Yes  No Neural Disorder  Yes  No

Serious injury  Yes  No Nasal/Sinus  Yes  No

Tumor or Cancer  Yes  No Type of Cancer: \_\_\_\_\_

Ear/Throat issues  Yes  No

Congenital Heart Defect  Yes  No

Hepatitis/Liver problems  Yes  No

High Blood Pressure  Yes  No

Radiation/Chemotherapy  Yes  No Year: \_\_\_\_\_

Asthma or Hay fever  Yes  No

Gastrointestinal Disorders  Yes  No

Are there any medical conditions we have not discussed that you feel we should be aware of?

Do you normally require antibiotic pre-medication prior to dental procedures?  Yes  No

Are you allergic to any of the following?

Yes  No Aspirin  Yes  No Erythromycin

Yes  No Codeine  Yes  No Penicillin

Yes  No Latex  Yes  No Nickel

Please list all other allergies:

DENTAL HISTORY

Chief complaint/ reason for visit today:

History of the following (Circle all that apply)

Trauma to teeth Finger/Thumb Sucking

Joint clicking Mouth breathing

Grinding Jaw locks shut/open

Snoring Clenching

Joint Pain Tongue Thrust

Gum disease Headaches/earaches

Jaw growth disorder Missing teeth

Previous orthodontic treatment? When? \_\_\_\_\_

EXPLAIN:

I hereby certify that I have reviewed the above medical and dental history and agree it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes. I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment.

\_\_\_\_\_ Date \_\_\_\_\_

Patient Signature

\_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature