FOR ADULTS: WELCOME TO OUR PRACTICE

Home #: ____________________
Work #: ____________________
Cell #: ____________________
Emergency #: ____________________

1.) ABOUT YOU

Today's date: __________ DOB: __________
Name: __________ AGE: __________

Last First Mi (Mr. Mrs. Ms.)

I preferred to be called: __________
Home #: __________
Work #: __________
SS #: __________
DL #: __________

Home Address:

Apt#

City State Zip

2.) ABOUT YOUR EMPLOYER:

Name: __________
Address: __________

How long have you worked there? __________
Occupation: __________

When & Where are the best times to reach you? __________
Other family members seen by us:

Who may we THANK for referring you? __________

3.) SPOUSE INFORMATION:

Name: __________
Employer: __________
WK#: __________
DL#: __________
SS#: __________
DOB:

DENTAL INFORMATION:

Previous/Present Dentist: __________
Street: __________
Phone: __________ **Last visit:** __________

4.) RESPONSIBLE PARTY INFO:

Name: __________

Billing address: __________

City State Zip

WK#: Ext. HM#:
Employer: __________

DL#: __________
SS#: __________

Emergency Contact:

Name: __________ Relation:
WK#: Ext. HM#:

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: __________
Ins. Address: __________

Insurance Co. Phone #: __________
Group/Policy # __________

Insured's Name: __________
Relationship to Patient: __________
Insured's DOB: __________
Insured's Employer: __________
SS#: __________
Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: __________
Ins. Address: __________

Insurance Co. Phone #: __________
Group/Policy # __________

Insured's Name: __________
Relationship to Patient: __________
Insured's DOB: __________
Insured's Employer: __________
SS#: __________

Orthodontic Coverage: YES NO

OR 1P (200)
Rev. 4/96

6) DENTAL HISTORY

Why have you come to the orthodontist today? ______

Are you currently in pain? Y N

Your current dental health is:

Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?

Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? ______

A day do you brush? ______

Types of bristles? Hard Medium Soft

7) MEDICAL HISTORY

Do you have a personal physician? Y N

Name: ______

Phone: ______ Last visit: ______

Your current physical health is:

Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain: ______

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: ______

Are you nursing? Y N

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

Y N Prothesis	Y N History of Scarlet Fever
Y N Heart attack	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum. Fev.	Y N Artificial Valves
Y N HIV+/AIDS	Y N Heart surgery/Pacmkr.
Y N Hemophilia	Y N Any Stays in Hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Mitral Valve Prolapse
Y N Tuberculosis	Y N Artificial bones/joints
Y N Shingles	Y N Sev./Freq. headaches
Y N Fever blister	Y N Hi/Lo blood pressure
Y N Venereal dis.	Y N Drug/Alcohol Abuse
Y N Ulcers/Colitis	Y N Blood Transfusion
Y N Heart Murm.	Y N Anemia/Radiation tmt.
Y N Emphysema	Y N Glaucoma
Y N Sinus Probs.	Y N Difficulty Breathing?
Y N Other:	

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin
Y N Codeine	Y N Dental Anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

______

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY — OFFICE USE ONLY — OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: ______ Date: ______

Doctor's comments: ______

______

Medical History Update:

1. Date: ______ Signature: ______

Comments: ______

2. Date: ______ Signature: ______

Comments: ______