

WELCOME!

*So that we might become better acquainted,
please complete the following:*



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Adult Patient Information

Patient's Name _____ Today's Date _____
Birth Date ___/___/___ Age ___ M F Email Address _____
Mailing Address _____ City _____ State ___ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____ Years Employed _____
Dentist _____ Date of Last Dental Check Up _____
Whom may we thank for referring you to our office? _____

Responsible Party Information

Self Spouse Other Name _____ Single Married Divorced Separated
Address _____ City _____ State ___ Zip _____ Yrs ___
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number ___ - ___ - ___ Birth Date ___/___/___ Relationship to Patient _____
Employer _____ Occupation _____ Years Employed _____

Insurance Information

Policy Holder's Name _____ Birth Date ___/___/___ SSN ___ - ___ - ___
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co Address _____ City _____ State ___ Zip _____
Phone _____

2nd Insured's Name _____ Birth Date ___/___/___ SSN ___ - ___ - ___
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co Address _____ City _____ State ___ Zip _____
Phone _____

Emergency Information

Name of nearest relative *not* living with you _____ Phone _____

Please turn over for more on the back...

Medical History

Name of your physician _____ Date of last exam _____

1. Are you in good health? Yes No
2. Do you have a health problem? Yes No If yes, explain _____
3. Do you have allergies to medications, medical products (latex) or, to the environment (dust mites, pollen, etc.)?
 Yes No If yes, please list: _____
4. Please list current prescription medications you are taking: _____
5. Have you ever taken or are taking bisphosphonates for osteoporosis? _____
6. (Women) Are you pregnant? Yes No
7. Have you been treated by a physician for any of the following conditions? (Check any that apply)

<input type="checkbox"/> Problems at Birth	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Heart Disease/Murmur	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Cleft Lip/Palate
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Speech or Hearing Problems
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Cancer/Radiation Therapy	<input type="checkbox"/> Tonsil, Adenoid, Sinus Problems
<input type="checkbox"/> Anemia/Hemophilia	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Emotional/Behavior Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Asthma	<input type="checkbox"/> Growth Problems

Dental History

What is your chief concern(s)? _____

Are you interested in: (please indicate all that apply)

- Information Treatment now Clarification of previous or conflicting information

Check any of the following that apply and explain below:

1. Any injuries or operations to the face, mouth, or teeth?
2. Do you know of any missing or extra permanent teeth?
3. Has any previous orthodontic treatment been rendered?
4. Do you have any speech difficulty?
5. Do you suffer from any jaw joint problems such as pain, clicking or popping?
6. Do you grind or clench your teeth during the day or night?
7. Inability to open mouth wide or move jaw normally?
8. Have you ever sucked your thumb or fingers? Until what age?
9. Teeth difficult to clean?
10. Awareness of any gum or bone problem around teeth?
11. Concerned about the appearance of your teeth?
12. Concerned about the appearance of your face and/or jaw structure?

Comments: _____

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. This office reserves the right to verify the credit status of potential patient and/or parents of patients prior to extending credit for treatment fees.

Signature _____ Relationship to Patient _____

Updates (date and initial) _____