FOR ADULTS: WELCOME TO OUR PRACTICE

1. ABOUT YOU

Today's date: ________ Age: ______ DOB: ________

☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Name: ____________________

Last First Middle

I prefer to be called: ____________________

Home#: ________ Cell#: ________

DL#: ________ Work#: ________

SS#: ____________________

Home Address:

____

____

City State Zip

2. ABOUT YOUR EMPLOYER

Name: ____________________

Address: ____________________

____

How long you have worked there? ________

Occupation: ____________________

When & where are the best times to reach you? ________

____

Other family members seen by us: ________

____

Whom may we THANK for referring you? ________

3. SPOUSE INFORMATION

Name: ____________________

Employer: ____________________

WK#: ________ DL#: ________

SS#: ____________________

DOB: ____________________

4. DENTAL INFORMATION

Previous / Present Dentist: ____________________

Street: ____________________

Phone#: ________ Last Visit: ________

5. RESPONSIBLE PARTY INFO

Name: ____________________

Billing address : ____________________

____

City State Zip

WK#: ________ Home#: ________

Cell#: ________ Email: ________

Employer: ____________________

SS#: ________ DL#: ________

EMERGENCY CONTACT:

Name: ________ Relation: ________

WK#: ________ Home#: ________

Cell#: ____________________

6. 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

7. 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

8. DENTAL HISTORY

Why have you come to the Orthodontist today? : ____________

Are you currently in pain? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had any serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Have you ever had pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? ____________

How many times a day do you brush? ____________

Types of bristles: ☐ Hard ☐ Medium ☐ Soft

9. MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Name: ____________

Phone #: ____________ Last Visit: ____________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a doctor? ☐ Yes ☐ No

Explain: ____________

Are you taking any prescription drugs? ☐ Yes ☐ No

List: ____________

FOR WOMEN ONLY:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#: ______

Are you nursing? ☐ Yes ☐ No

10. HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Prothesis	☐	☐	History of Scarlet Fever
☐	☐	Heart attack	☐	☐	Congenital Heart Def.
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Artificial valves
☐	☐	HIV+/AIDS	☐	☐	Heart surgery/pacmkr
☐	☐	Hemophilia	☐	☐	Any Stays in Hospital
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Mitral valve prolapse
☐	☐	Tuberculosis	☐	☐	Artificial bones / joints
☐	☐	Shingles	☐	☐	Sev./freq. headaches
☐	☐	Fever Blister	☐	☐	Hi / low blood pressure
☐	☐	Venereal Disease	☐	☐	Drug / alcohol abuse
☐	☐	Ulcers / colitis	☐	☐	Blood transfusion
☐	☐	Heart murmur	☐	☐	Anemia/Radiation tx
☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Sinus problems	☐	☐	Difficulty Breathing
☐	☐	Other ____________			

11. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Erythromycin
☐	☐	Codeine	☐	☐	Dental Anesthetics
☐	☐	Latex	☐	☐	Metal
☐	☐	Penicillin	☐	☐	Other ____________

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

11. 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: ____________

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: ____________

1. Date: ____________ Signature: ____________

Comments: ____________