

**PATIENT INFORMATION
ADULT**

DATE _____

NAME(First, Middle, Last): _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Birthdate _____ Age _____ Sex: M F

Employer _____

Social Security Number _____

Spouse's Name _____

Work Phone _____ Cell Phone _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

DENTIST NAME & ADDRESS _____

IMMEDIATE ORTHODONTIC CONCERN OR PROBLEM _____

RESPONSIBLE PARTY INFORMATION (if different than above):

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

PRIMARY DENTAL INSURANCE COVERAGE

Insured Name: _____

Pt relation to Insured: Self/Spouse/Child/Other _____

Address (If different than above) _____

S/S No. _____ DOB: ___ / ___ / ___ Employer: _____

Address of Employer: _____

Insurance Co.: _____ Group No: _____ ID No: _____

Address of Ins. Co: _____

EMERGENCY INFORMATION:

Name of nearest relative not living with you _____

Address _____

Phone Number _____

Please continue on the reverse side of page...OVER

HEALTH QUESTIONNAIRE

NAME & ADDRESS OF PHYSICIAN _____

DATE OF LAST PHYSICAL EXAM _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING: INDICATE WITH AN "X"

- | | |
|---|---|
| <input type="checkbox"/> TEETH SENSITIVE TO COLD, HEAT,
SWEETS OR PRESSURE | <input type="checkbox"/> ORTHODONTIC TREATMENT |
| <input type="checkbox"/> BLEEDING GUMS HOW LONG _____ | <input type="checkbox"/> MOUTH BREATHING |
| <input type="checkbox"/> FOOD IMPACTION | <input type="checkbox"/> ORAL HABITS, I.E., FINGERNAIL BITING,
CHEEK BITING, ETC. |
| <input type="checkbox"/> CLENCHING OR GRINDING | <input type="checkbox"/> CIGARETTES, PIPE OR CIGAR SMOKING |
| <input type="checkbox"/> BURNING OF TONGUE | <input type="checkbox"/> FREQUENT BRUSHING |
| <input type="checkbox"/> SWELLING OR LUMPS IN MOUTH | <input type="checkbox"/> DENTAL FLOSS |
| <input type="checkbox"/> PAIN AROUND EAR | <input type="checkbox"/> WATER JET DEVICE |
| <input type="checkbox"/> UNUSUAL SOUNDS IN EAR WHEN EATING | <input type="checkbox"/> FLUORIDE SUPPLEMENTS |
| <input type="checkbox"/> BAD BREATH | <input type="checkbox"/> THUMBSUCKING |
| <input type="checkbox"/> UNPLEASANT TASTE | <input type="checkbox"/> TONGUE THRUST |
| <input type="checkbox"/> UNFAVORABLE DENTAL EXPERIENCE | <input type="checkbox"/> DO YOU PLAY A MUSICAL INSTRUMENT?
IF SO, WHAT KIND? _____ |
| <input type="checkbox"/> COMPLICATIONS FROM EXTRACTIONS | |
| <input type="checkbox"/> PERIODONTAL TREATMENT | |

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL PROCEDURES: YES NO UNSURE

HAVE YOU EVER TAKEN FEN-PHEN OR REDUX: YES NO

MEDICAL HISTORY

- | | |
|---|---|
| <input type="checkbox"/> ALLERGIES TO DRUGS
IF SO, WHAT _____ | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> ALLERGIES TO ANESTHETICS | <input type="checkbox"/> LIVER PROBLEMS OR HEPATITIS |
| <input type="checkbox"/> ANY HEART AILMENTS | <input type="checkbox"/> PSYCHIATRIC CARE / EMOTIONAL PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> NEUROLOGICAL PROBLEMS | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> LEARNING DISABILITIES | <input type="checkbox"/> JOINT REPLACEMENT |
| <input type="checkbox"/> RADIATION TREATMENTS | <input type="checkbox"/> IMMUNE SYSTEM DISORDERS (AIDS, HIV, ARC) |
| <input type="checkbox"/> MALIGNANCIES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> EXCESSIVE BLEEDING FROM CUT
OR EXTRACTION | <input type="checkbox"/> EYE DISORDERS |
| <input type="checkbox"/> ANEMIA OR BLOOD PROBLEMS | <input type="checkbox"/> TONSILITIS |
| <input type="checkbox"/> THYROID | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> ULCER OR COLITIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> PREGNANT (IF SO, WHAT MONTH? _____) |
| <input type="checkbox"/> HAY FEVER OR ALLERGIES IN GENERAL | <input type="checkbox"/> VENERAL DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> INJURIES TO MOUTH/JAW AREA |
| | <input type="checkbox"/> OTHER _____ |

DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING ANY MEDICATIONS NOT MENTIONED ABOVE

SIGNATURE OF RESPONSIBLE PARTY _____

RELATIONSHIP _____

DATE: _____