New Adult Patient Information

Patient Information

Patient's Name: _____
Last First Middle Likes to be called

Date of Birth: _____ Age: _____ Sex: _____ E-Mail _____

Phone: _____ School: _____ Grade: _____

Home Address: _____
Street City State Zip

Marital Status: Married _____ Separated _____ Divorced _____ Widowed _____

Patient's Dentist: _____ Physician: _____

How did you hear about us? _____

Names & Ages of Children: _____

Occupation: _____ Work Phone: _____

Employed by: _____

Spouse's Name: _____ Work Phone: _____

Occupation: _____ Employed by: _____

Dental Insurance Information (All information is needed to give accurate quote)

Person responsible for account _____
Last First Middle

DOB: _____ Social Security Number: _____

Relationship to patient: _____

Address (if different from patient) _____
Street City State Zip

Phone: _____ Cell Phone/Alternate Phone: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____
Street City State Zip

Dental Insurance Company: _____

Dental Insurance Address: _____

Contact #: _____ Group #: _____ Subscriber #: _____

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

Now or in the past, have you had:

Y N Birth Defects or hereditary problems
Y N Bone fractures, any major accidents
Y N Rheumatoid or arthritic conditions
Y N Endocrine or thyroid problems
Y N Kidney Problems
Y N Diabetes
Y N Cancer, tumor, radiation treatment or chemotherapy
Y N Stomach Ulcer or hyperacidity
Y N Polio, mononucleosis, tuberculosis, pneumonia
Y N Problems of immune system
Y N AIDS or HIV Positive
Y N Hepatitis, jaundice or liver problem
Y N Fainting spells, seizures, epilepsy or neurological problems
Y N Mental Health disturbance or depression
Y N Vision, hearing, tasting or speech difficulties
Y N Loss of weight recently, poor appetite
Y N History of eating disorder
Y N Excessive bleeding or bruising tendency, anemia or bleeding disorder
Y N High or low blood pressure
Y N Tired easily
Y N Chest pain, shortness of breath or swelling ankles
Y N Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease
Y N Skin disorder
Y N Do you have a well-balanced diet?
Y N Frequent headaches, colds or sore throats
Y N Eye, ear, nose or throat condition
Y N Hay fever, asthma, sinus trouble or hives
Y N Tonsil or adenoid conditions
Y N Osteoporosis

Allergies or reactions to any of the following:

Y N Local anesthetics (Novocaine or Lidocaine)
Y N Latex (gloves/balloons)
Y N Ibuprofen (Motrin/Advil)
Y N Penicillin or other antibiotics
Y N Sulfa Drugs
Y N Codeine or other narcotics
Y N Metals (jewelry, clothing snaps)
Y N Aspirin
Y N Vinyl
Y N Acrylic
Y N Animals
Y N Foods (specify): _____
_____
Y N Other substances (specify): _____
_____

List of any medications?

Medication_____ Taken for_____

Medication_____ Taken for_____

Do you currently have or ever had a substance abuse problem? **Yes/No**

Do you chew or smoke tobacco? **Yes/No**

Other physical problems or symptoms?
Describe: _____
_____

Women Only:
Are you pregnant? **Yes/No**
Are you anticipating becoming pregnant? **Yes/No**

Family Medical History:
Do your parents or siblings have, or have ever had any of the following health problems?
If so please explain:_____
___Bleeding disorders
___Severe Allergies
___Jaw Size Imbalance
___Diabetes
___Arthritis
___Unusual Dental Problems

Dental History

Now or in the past, has the patient had:

Y N Permanent or “extra” (supernumerary) teeth
Y N Congenitally missing teeth?
Y N Chipped or otherwise injured primary (baby) or permanent teeth?
Y N Teeth sensitive to hot or cold; teeth throb or ache
Y N Jaw fractures, cysts or mouth infections
Y N “Dead Teeth” or root canals treated
Y N Bleeding gums, bad taste of mouth odor
Y N Periodontal “gum problems”
Y N Food impactions between teeth
Y N “Gum boils” frequent canker sores or cold sores
Y N Thumb, finger, or sucking habit?
Y N Abnormal swallowing habit (tongue thrusting)
Y N History of speech problems
Y N Mouth breathing habit, snoring or difficulty in breathing
Y N Tooth grinding or jaw clenching
Y N Any pain, clicking or locking in jaw or ringing in the ears
Y N Any pain or soreness in the muscles of the face or around the ears
Y N Difficulty in chewing or jaw opening
Y N Have you ever been treated for “TMD” or “TMJ”?
Y N Aware of loose, broken or missing restorations
Y N Any teeth irritating cheek, lip, tongue, or palate
Y N Concerned about spaced, crooked or protruding teeth
Y N Aware of concerned about under or over developed jaw
Y N Any relative with similar tooth or jaw relationships
Y N Any wisdom tooth problems
Y N Had periodontal (gum) treatment
Y N Had any serious trouble associated with any previous dental treatment
Y N Ever had a prior orthodontic examination or treatment
Y N Would you object to wearing orthodontic appliances (braces) should they be indicated

How often do you brush:_____ Floss:_____

What is your primary concern?_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed:_____ Date Signed:_____
(Parent or Guardian)

Signed:_____ Date Signed:_____
(Dental Staff Member)