



## New Adult Patient Information

### Patient Information

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ E-Mail \_\_\_\_\_

Phone: \_\_\_\_\_ Preferred method of contact: \_\_\_\_\_

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: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

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

Policy holders name: \_\_\_\_\_

Last First Middle

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Street City State Zip

Policy holders Phone: \_\_\_\_\_ Cell Phone/Alternate Phone: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Insurance Address: \_\_\_\_\_

Street City State Zip

Subscriber ID or Policy #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Group #: \_\_\_\_\_

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

### 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

**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: \_\_\_\_\_

\_\_\_\_\_



## 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)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Name Please Print

\_\_\_\_\_  
Signature of Patient (Parent or Guardian if Child)

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

\_\_\_\_\_  
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) \_\_\_\_\_



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Furthermore, I understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**\*\*You May Refuse to Sign This Acknowledgement\*\***

\*If you choose to decline this photo release, please write declined across page\*