PLEASE COMPLETE EACH LINE.

Email Address: ____________

ADULT FORM

	PATIENT	SPOUSE
NAME		
NICKNAME		
ADDRESS: Street		
City and Zip Code		
HOME PHONE NUMBER		
EMPLOYER		
WORK PHONE NUMBER		
BIRTHDATE		
AGE		
SOCIAL SECURITY NUMBER		
DENTIST		
DENTIST'S ADDRESS		
PHYSICIAN		
PHYSICIAN'S ADDRESS		
Who referred you to our office?		
How long with present employer?		
How long at home address?		
INSURANCE INFORMATION:		
Name of medical insurance.		
Address: Street		
City and Zip Code		
Phone number of medical insurance.		
Name of dental insurance.		
Address: Street		
City and Zip Code		
Phone number of dental insurance.		
Does your dental insurance cover braces?	Yes ❑ No ❑	Yes ❑ No ❑

Person responsible for account? ____________

Has any member of your family been a patient in this office? Yes ❑ No ❑

Names: ____________

Friends who are patients in our office? ____________

Names: ____________

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
❏	❏	Diabetes	❏	❏	Anemia	❏	❏	Prolonged Bleeding
❏	❏	Pneumonia	❏	❏	Epilepsy	❏	❏	Nervous Disorders
❏	❏	Heart Trouble	❏	❏	Asthma	❏	❏	Hepatitis
❏	❏	Rheumatic Fever	❏	❏	Kidney Involvement	❏	❏	Endocrine Problems
❏	❏	Bone Disorders	❏	❏	Tuberculosis	❏	❏	Frequent Colds and/or Flu
❏	❏	Adenoids Removed Age _____	❏	❏	Fainting or Dizziness	❏	❏	HIV Positive
❏	❏	Tonsils Removed Age _____	❏	❏	AIDS	❏	❏	Thyroid Problems
❏	❏	Emotional Problems						

List any other serious illnesses or medical problems.

List any allergies(including those to any drugs or medications).

List any drugs or medications now being taken.

DENTAL HISTORY

	Yes	No	
Do you suffer from a frequent sore neck or headaches?	❏	❏	
Do you clench or grind your teeth?	❏	❏	At night? ❏ Yes ❏ No
Do you have pain or clicking upon opening or closing the mouth?	❏	❏	
Have there been any injuries to the face, mouth or teeth?	❏	❏	
Are you a mouth breather?	❏	❏	
Have you ever been informed of any missing or extra permanent teeth?	❏	❏	
Have you had any previous orthodontic consultation or treatment?	❏	❏	
Date of last dental appointment ________________ Were x-rays taken?	❏	❏	

What would you like treatment to accomplish? ____

____

I UNDERSTAND WHERE APPROPRIATE

CREDIT BUREAU REPORTS MAY BE OBTAINED Signature ________________________ Date: ______________

··· DO NOT WRITE BELOW THIS LINE ···

Range of Motion	R_____	L_____	Opening_____	A	B	C
Clicking in Joints	Yes_____	No_____				
Headaches	Yes_____	No_____				
TMJ Disorder	Yes_____	No_____				

Notes: ____

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