ADULT PATIENT **INFORMATION**

WELCOME TO OUR OFFICE

Date_____
Patient's Name_____Male _____ Female _____
Full Address _____City_____Zip_____
Full Mailing Address _____ __City_____Zip_____
How long at this address (if less than 3 years)_____ Social Security # _____
Home Phone _____ Work Phone _____D.O.B._____
Marital Status: Single _____Married_____ Divorced _____ Widowed _____
Employer_____Occupation_____ # Years Employed_____

Spouse's Name _____ Spouse's Social Security # _____Spouse's D.O.B._____
Spouse's Employer_____Occupation_____# yrs. Employed____

Dentist _____Who may we thank for referring you _____

INSURANCE INFORMATION

Insured's Name _____ D.O.B._____ Social Security # _____
Insurance Company _____Group # _____Effective Date:_____
Insurance Address _____
Insured's Employer _____

Do you have dual coverage? Yes_____ No _____ If yes, please continue:
Insured's Name _____ D.O.B. _____ Social Security # _____
Insurance Company _____Group #_____Effective Date:_____
Insurance Address _____
Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete address _____
Phone # _____ Relationship to Patient _____

Signature _____

I understand that where appropriate, credit bureau reports may be obtained.

For Office Use: CC TC FO OB

PATIENT HEALTH QUESTIONNAIRE FOR: _____

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

CHIEF CONCERN(S):

_ Crowded teeth
_ Over bite
_ "Buck teeth"
_ Receded jaw
_ Prominent jaw
_ Gummy smile
_ Spacing between teeth
_ Gum disease/recession
_ Missing teeth
_ Jaw dysfunction
_ Mouth too small
_ Clicking jaw joint
_ Protrusion of teeth
_ Ears Ring/Stuffy
_ Headache/Face pain
_ Neck pain
_ Jaw pain
_ Other: _____

FAMILY MEMBERS THAT HAVE HAD/ OR ARE CURRENTLY IN, ORTHODONTIC TREATMENT:

Father_____Mother_____Brother_____Sister_____
_ Other: _____

NAMES AND AGES OF CHILDREN:

_____Age:_____
_____Age:_____
_____Age:_____

CURRENT PHYSICAL HEALTH

_ Excellent _ Good
_ Fair _ Poor

CURRENT EMOTIONAL HEALTH:

_ Excellent _ Good
_ Fair _ Poor

KNOWN OR SUSPECTED ALLERGIES:

_ Antibiotics: _____
_ Pain medications:_____
_ Foods: _____
_ Environmental allergies: _____
_ None

CONDITIONS YOU HAVE HAD:

_ AIDS
_ Allergies
_ Asthma
_ Autoimmune disorders
_ Blood disease
_ High blood pressure
_ Low blood pressure
_ Bone disorders
_ Cancer
_ Diabetes
_ Dizziness
_ Eating disorders
_ Endocrine disorder
_ Emotional disorder
_ Female disorder
_ HIV positive status
_ Hepatitis
_ Heart disease
_ Heart murmur
_ Hearing disorder
_ Kidney disease
_ Rheumatic fever
_ Ringing of the ears
_ Sleep disturbance
_ History of trauma
_ Teeth _ Face _ Jaws _ Head
_ None of the Above
_____ PLEASE INITIAL

CURRENT MEDICATIONS:

_ Anti Depressants:_____
_ Heart medication:_____
_ Antibiotics: _____
_ Appetite Suppressants: _____
_ Pain medications:_____
_ Vitamins:_____
_ Birth control:_____
_ Muscle relaxants:_____
_ Insulin:_____
_ Other: _____
_ None
_____ PLEASE INITIAL

PRIMARY BREATHING PATTERN:

_ Mouth _ Nose

DIFFICULTY CHEWING?

_ Yes
_ Teeth don't meet well
_ Pain when chewing
_ Other: _____
_ No

CHECK ALL THAT APPLY:

_ Frequent sore throat/tonsillitis
_ Speech concerns
_ Pain in the RIGHT jaw joint
_ Pain in the LEFT jaw joint
_ Clicking/popping in RIGHT jaw joint
_ Clicking/popping in LEFT jaw joint
_ Current thumb/finger sucking habit
_ Previous thumb/finger sucking habit
_ Lip biting/sucking habit
_ Grind teeth
_ Clench jaws
_ Tongue thrust when swallowing

HAVE YOU HAD A PREVIOUS ORTHODONTIC EXAM/CONSULTATION?

_ Yes:
_ With Dr. _____
_ No

_ Sometimes: _____

FREQUENCY OF DENTAL CHECKUPS?

_ Once per year
_ Twice per year
_ More than twice a year
_ Emergencies Only
_ Never
_ Date of last cleaning_____

HOW DO YOU FEEL ABOUT WEARING BRACES

_ Wants treatment
_ Only if necessary
_ Unwilling

But will cooperate if treatment is needed

_ Uncooperative

PHYSICIAN NAME:

_____

ADDITIONAL MEDICAL, DENTAL, OR SURGICAL HISTORY?

_____

_____

ARE YOU REQUIRED TO BE PRE-MEDICATED PRIOR TO DENTAL WORK: YES_____ NO_____

Patient Signature Printed Name Date

DOCTOR'S NOTES:

_____

_____

_____

_____

DO YOU SNORE WHEN YOU SLEEP?

_ Yes _ No