

PATIENT INFORMATION FORM FOR ADULTS

FULL NAME _____ Nick Name _____

Age _____ Birthdate _____ SS# _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

General Dentist _____ Referred By _____

Address _____
City State Zip

E-Mail Address _____

Home Phone Number _____ Cell Phone Number _____

E-Mail Address _____

Place of employment _____ Occupation _____

Business Address _____
City State Zip

Business Phone _____

Spouse's Name _____ Birthdate _____ SS# _____

Place of Employment _____ Occupation _____

Business Address _____
City State Zip

Business Phone _____

If you have moved within the last two years, list previous address. _____

In case of emergency, please list nearest relative _____

Dental Insurance name and address _____

Insured's Name _____ ID# _____ Group# _____

Names and ages of children in family _____

Authorization:

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

HEALTH QUESTIONNAIRE

DATE _____

NAME _____

1. Do you have regular Dental-Medical examinations? _____ Yes No
Last Dental Appt. and Procedures? _____
Date of last dental x-rays? _____
2. Has there been any change in the patient's general health within the past year? _____ Yes No
If yes explain: _____
3. Name and address of family physician: _____
Are you currently under treatment and if so for what condition? _____
4. Please list any prescription medications patient is taking _____
5. Have you been hospitalized or had any serious illness and if so for what condition, illness or operation? _____ Yes No
6. Do you have or have you had any of the following? _____ Yes No
 - A. Scarlet Fever, Rheumatic Fever/Heart Disease? _____ Yes No
 - B. Congenital Heart Lesions? _____ Yes No
 - C. Mitral Valve Prolapse/ Heart Murmur? _____ Yes No
 - D. Allergies to Drugs, Anesthetics, or Other? _____ Yes No
Please Specify _____
 - E. Sinus problems, Hay Fever, Asthma? _____ Yes No
 - F. Epilepsy, Cerebral or Spastic Condition? _____ Yes No
 - G. Blood Disorder (Anemia, Hemophilia)? _____ Yes No
 - H. Herpes? _____ Yes No
 - I. Hepatitis? _____ Yes No
Please Specify _____
 - J. Tuberculosis? _____ Yes No
 - K. HIV/AIDS? _____ Yes No
 - L. Latex Allergies? _____ Yes No
7. Have you come in contact with someone with Hepatitis, Tuberculosis, or HIV/AIDS? _____ Yes No
If yes, please specify. _____
8. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? _____ Yes No
9. Have you ever required a blood transfusion? _____ Yes No
If so, explain circumstances _____
10. Have you had surgery or x-ray treatment for a tumor, growth or condition of the mouth, lips? _____ Yes No
11. Are you employed in any situation which they are exposed regularly to x-rays? _____ Yes No
12. Women: Are you pregnant? _____ Yes No

NAME _____

1. Please tell us why you think you need to see an orthodontist. _____

2. Have you ever experienced any of the following:

- A. Trouble associated with previous dental treatment _____ Yes No
- B. Dental discomfort at this time _____ Yes No
- C. Current gum bleeding _____ Yes No
- D. Tooth sensitivity to cold, hot, sweets or chewing _____ Yes No
- E. Jaw clicking _____ Yes No
- F. Pain in or around the ears _____ Yes No
- G. Frequent sores in and around the mouth _____ Yes No
- H. Fear of dentistry _____ Yes No
- I. Had periodontal (gum) treatment _____ Yes No
- J. Had orthodontic treatment before _____ Yes No
- K. Thumb or finger sucking habits? _____ Yes No

Please specify _____

3. Do you breathe through your mouth primarily? _____ Yes No

4. Do you grind or clench your teeth? _____ Yes No

5. Have you ever been told that you have a tongue thrust or reverse swallowing pattern? _____ Yes No

6. Have your tonsils and or adenoids been removed? _____ Yes No

If yes, please indicate which. _____

7. Is there any hereditary background, which may contribute to this orthodontic problem?

Please specify. _____

8. Hobbies or special interests? _____

DATE **MEDICAL AND DENTAL NOTES (FOR DOCTOR'S USE)**

DOCTOR'S SIGNATURE

ORTHODONTIC EVALUATION

	TEETH PRESENT			
	ALIGNMENT	PROFILE		
	TRANSVERSE	SAGITTAL		
	VERTICAL			
	SEVERITY:	MARKED	MODERATE	MINIMUM
	THER. MOD:	GOOD	FAIR	POOR
	MOTIVE, HYGIENE:	GOOD	FAIR	POOR

REMARKS:

Large empty rectangular area for writing remarks.