NEW ADULT PATIENT FORM, ABOUT YOU:

Today's date: DOB: ______________
AGE: ______________

Name:

last first mi (Mr. Mrs. Ms)

I prefer to be called:______________________________
Home phone:___________________________________
Work phone: ___________________________________
Email:____
Social Security #: ________________________________
Home address:

Street Apt.

City State Zip

ABOUT YOUR EMPLOYER

Name:____
Address:_______________________________________

How long have you worked there?________________
Occupation:____________________________________
When/where are best times to reach you?

Other family members seen by us:

Who may we thank for referring you?

SPOUSE INFORMATION

Name:____
Employer:______________________________________
Work Phone:___________________________________
Email:____
Social Security #:_______________________________
Date of Birth:__________________________________

DENTAL INFORMATION

Previous/Present Dentist:_________________________

City/Sate

Phone: ____

Last visit:_______________________________________

RESPONSIBLE PARTY INFORMATION

Name: ____
Billing address: ____________________________________

City State Zip

Work phone: _____________________________________
Cell phone: _______________________________________
Email: ____
Employer: ____
Drivers License # ___________________________________
Social Security # ____________________________________

Emergency Contact

Name: ____
Wk # ____________________Home __________________
Relationship;_______________________________________

PRIMARY DENTAL INSURANCE

Ins. Name: ____
Ins. Address: ______________________________________

Insurance Phone: ___________________________________
Group policy #:_____________________________________

Insured's Name: __________________________________
Relationship to patient:_____________________________
Insured's DOB: ___________________________________
Insured's Employer:_________________________________
Social Security #:__________________________________
Orthodontic Coverage: YES NO

SECONDARY DENTAL INSURANCE

Ins. Name: ____
Ins. Address: ______________________________________

Insurance Phone: ___________________________________
Group policy #:_____________________________________

Insured's Name: __________________________________
Relationship to patient:_____________________________
Insured's DOB: ___________________________________
Insured's Employer:_________________________________
Social Security #:__________________________________
Orthodontic Coverage: YES NO

DENTAL HISTORY

Why have you come to the orthodontist today?

Ary you currently in pain? Y N

Your current dental health is:

Good Fair Poor

Have you ever had serious/difficult problems assoicated with previous dental work? Y N

Have you ever had pain or tenderness in the jaw joint (TMJ/TMD)? Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? ____________

How many times a day do you brush? _____________

Type of bristles? Hard Medium Soft

MEDICAL HISTORY

Do you have a personal physician? Y N

Name: ____

Phone: _______________________Last visit ________

Your current physical health is?

Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain ___________________________________

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY

Areyou taking birth control pills? Y N

Are you pregnant? Y N

Are you nursing? Y N

Have you ever had any of the following diseases or medical conditions?

Y N Prosthesis	Y N Scarlet fever
Y N Heart Attack	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum Fever	Y N Artificial Valves
Y N HIV+/AIDS	Y N Heart surgery/Pacemaker
Y N Hemophilia	Y N Any stays in hospital
Y N Asthma	Y N Kidney/Liver problems
Y N Hepatitis	Y N Mitral Valve Prolapse
Y N Tuberculosis	Y N Artificial bones/joints
Y N Shingles	Y N Severe/freq. head aches
Y N Fever blister	Y N Hi/Low blood pressure
Y N Venereal dis.	Y N Drug/alcohol abuse
Y N Ulcers/Colitis	Y N Blood transfusion
Y N Heart Murm.	Y N Anemia/Radiaition tmt.
Y N Emphysema	Y N Glaucoma
Y N Sinus problems	Y N Difficulty breathing
Y N Other:	

Are you allergic to any of the following?

Y N Aspirin	y N Erythromycin
Y N Codeine	Y N Dental anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

I understand the information that I have given is correct to the best of my knowledge that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

____

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: ______________ Date: _________________

Doctor's comments: ____________________________

OFFICE USE ONLY

Medical History Update:

1. Date: ____________ Signature:__________________

Comments:______________________________________

2. Date: ____________ Signature:__________________

Comments:______________________________________