



Welcome to our office! Please complete this form and bring it with you to your examination appointment.

Examination Date \_\_\_\_\_  
Day Date Time

### ADULT PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Age: Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Social Security Number \_\_\_\_\_ Business # \_\_\_\_\_

Spouse \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Social Security Number \_\_\_\_\_ Business # \_\_\_\_\_

Children / Ages \_\_\_\_\_

Special hobbies / interests \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_ Family Dentist \_\_\_\_\_

Names of other family members treated in this office \_\_\_\_\_

Do you have orthodontic insurance benefits?  No  Yes If yes, see other side of form.

Person responsible for account (if other than above).

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business # \_\_\_\_\_

Credit information will be verified for each account.

### EMERGENCY INFORMATION

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

# ORTHODONTIC INSURANCE

In order to assist you in receiving the maximum benefit from your orthodontic insurance, please complete the following information.

## PRIMARY

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
(800 # if available)  
Group # \_\_\_\_\_  
(Plan, Local, Policy #)  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_

## SECONDARY

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
(800 # if available)  
Group # \_\_\_\_\_  
(Plan, Local, Policy #)  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_

I authorize release of any information relating to this claim and need to have my signature on file for purposes of claim processing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### For Office Use Only

Primary Eligibility \_\_\_\_\_ Yes \_\_\_\_\_ No  
LTM \_\_\_\_\_ % \_\_\_\_\_  
Deductible \_\_\_\_\_  
Age Restrictions \_\_\_\_\_  
Cont of Tx \_\_\_\_\_ Yes \_\_\_\_\_ No  
Monthly/Qtrly \_\_\_\_\_  
Available Benefit \_\_\_\_\_

Secondary Eligibility \_\_\_\_\_ Yes \_\_\_\_\_ No  
LTM \_\_\_\_\_ % \_\_\_\_\_  
Deductible \_\_\_\_\_  
Age Restrictions \_\_\_\_\_  
Cont of Tx \_\_\_\_\_ Yes \_\_\_\_\_ No  
Monthly/Qtrly \_\_\_\_\_  
Available Benefit \_\_\_\_\_

If patient is not eligible for orthodontic benefits, is there coverage for diagnostic procedures? \_\_\_\_\_ Yes \_\_\_\_\_ No

If patient is not eligible for orthodontic benefits, is there coverage for diagnostic procedures? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date \_\_\_\_\_ By \_\_\_\_\_

Date \_\_\_\_\_ By \_\_\_\_\_

## ADULT MEDICAL HISTORY

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Date \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

- Have you experienced any health problems?     No     Yes    Explain \_\_\_\_\_
- Any major change in your health recently?     No     Yes    Explain \_\_\_\_\_
- Are you currently under physician's care?     No     Yes    Explain \_\_\_\_\_
- Are you currently taking medications?     No     Yes    List \_\_\_\_\_
- Are you allergic to any medications?     No     Yes    List \_\_\_\_\_
- Have you ever been hospitalized?     No     Yes    When \_\_\_\_\_
- Have your tonsils/adenoids been removed?     No     Yes    When \_\_\_\_\_
- Do you have any physical or mental impairments?     No     Yes    Explain \_\_\_\_\_
- Any hearing, sight or speech coordination problems?     No     Yes    Explain \_\_\_\_\_
- If applicable, are you pregnant?     No     Yes    Due date \_\_\_\_\_

Please check if you have a history of any of the following conditions:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Hemophilia         | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Frequent Headaches      |
| <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Bone Disorders          |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Developmental Disorders |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Mouth Breather          |
| <input type="checkbox"/> Endocrine Disorders      | <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Herpes (Fever Blisters) |
| <input type="checkbox"/> Growth Disorders         | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> AIDS                    |
| <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> H.I.V. Positive         |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Fainting Episodes  | <input type="checkbox"/> Hepatitis (A)           |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Hepatitis (B)           |
| <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Nervous/Anxious    | <input type="checkbox"/> Hepatitis (C)           |
| <input type="checkbox"/> Prolonged Bleeding       | <input type="checkbox"/> Hives/Rash         | <input type="checkbox"/> Drug Addiction          |

Are there any other conditions/problems of which we should be aware?

Comments: \_\_\_\_\_

### MEDICAL HISTORY UPDATE:

Date	Comments	Signature

# ADULT DENTAL HISTORY

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Frequency of dental checkups? \_\_\_\_\_ Date of last visit? \_\_\_\_\_

How many times per day do you brush? \_\_\_\_\_

Do you floss daily?  No  Yes

Do you receive topical fluoride?  No  Yes

Is there any unfinished dental care to be completed?  No  Yes Explain \_\_\_\_\_

Are you frightened about dental treatment?  No  Yes Explain \_\_\_\_\_

Have you had an unpleasant experience in a dental office?  No  Yes Explain \_\_\_\_\_

Do you play any musical instrument?  No  Yes What type? \_\_\_\_\_

Any recent changes in your bite/dental alignment?  No  Yes Explain \_\_\_\_\_

Have you consulted an orthodontist previously?  No  Yes With whom? \_\_\_\_\_

Have you undergone any prior orthodontic treatment?  No  Yes By whom? \_\_\_\_\_

Are you satisfied with the prior treatment?  No  Yes Explain \_\_\_\_\_

Have any other family members had a similar dental pattern?  No  Yes Who? \_\_\_\_\_

Was it treated?  No  Yes By whom? \_\_\_\_\_

Have you ever sustained any injury to mouth, teeth  
jaws, neck or head? \_\_\_\_\_  No  Yes Explain \_\_\_\_\_

Have you ever had muscular soreness around head/neck?  No  Yes problems with bleeding gums?  No  Yes

oral surgery procedure?  No  Yes periodontal (gum) treatment?  No  Yes

prosthodontic (crown & bridge) treatment?  No  Yes endodontic (root canal) treatment?  No  Yes

Are your teeth abnormally sensitive?  No  Yes Explain \_\_\_\_\_

Do you have difficulty in swallowing/chewing food?  No  Yes Explain \_\_\_\_\_

Are you self-conscious about wearing braces?  No  Yes Explain \_\_\_\_\_

What is your chief concern regarding your teeth? \_\_\_\_\_

What are the dentist's concerns regarding your teeth? \_\_\_\_\_

Do you desire an improved dental appearance?  No  Yes

Do you clench/grind your teeth?  No  Yes When? \_\_\_\_\_

Do you have a nail biting habit?  No  Yes

Do you have a lip biting habit?  No  Yes

Do you have a history of canker sores?  No  Yes

Have you ever had jaw joint pain?  No  Yes jaw joint clicking?  No  Yes

jaw joint locking?  No  Yes jaw joint popping?  No  Yes

jaw joint grating noises?  No  Yes ringing in ears?  No  Yes

I certify that the above medical history is accurate at this time. If there are future changes, I will inform this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Treatment Coordinator/Date \_\_\_\_\_