ADULT PATIENT INFORMATION

Patient's name_____Birthdate_____

Address_____

_____

Mailing Address if different_____

Home phone_____ Work phone_____

Cell Phone_____

Email Address_____

Employer_____Occupation_____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced__

Spouse's Name_____

Who may we thank for referring you to our office?_____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

Address_____ Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes	No	Are you taking any medication?
Yes	No	Are you allergic to any medication?
Yes	No	Do you have a history of a major illness?
Yes	No	Have you had any operations?
Yes	No	Have you ever been involved in a serious accident?
Yes	No	Have you ever smoked or chewed tobacco?
Yes	No	Have seen a physician in the last 12 months? Why?
Yes	No	Female Patients only: Are you pregnant?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes
Pneumonia	Hepatitis/Liver problems
Anemia	Dizziness
Prolonged Bleeding	Herpes
Arthritis	Epilepsy
Radiation/Chemotherapy	High Blood Pressure
Asthma or Hayfever	Gastrointestinal Disorders
Rheumatic Fever	HIV /Aids
Bone Disorders	Heart Problems
Tuberculosis	Kidney problems
Congenital Heart Defect	Heart Murmurs
Tumor or Cancer	Nervous Disorders

Are there any medical conditions we have not discussed that you feel we should be aware of?

DENTAL HISTORY

General Dentist_____ Date of last visit_____

What concerns you most about your teeth?_____

Yes	No	Are you presently in any dental pain?
Yes	No	Have you ever experienced any unfavorable reaction to dentistry?
Yes	No	Have your wisdom teeth been removed?
Yes	No	Have you ever lost or chipped any teeth?
Yes	No	Have there been any injuries to face, mouth, or teeth?
Yes	No	Is any part of your mouth sensitive to temperature? Where?
Yes	No	Is any part of your mouth sensitive to pressure? Where?
Yes	No	Do your gums bleed when you brush?
Yes	No	Do you have any type of thumb or tongue habit?
Yes	No	Are you a mouth breather?
Yes	No	Have you ever seen an orthodontist? If yes, when?
Yes	No	What is your attitude toward receiving orthodontic treatment?
Yes	No	Has anyone in your family received orthodontic treatment?
		How did they feel about the result?
Yes	No	Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes	No	Are you aware of your jaw clicking or popping?
Yes	No	Are you aware of clenching your teeth during the day?
Yes	No	Have you ever been told that you grind your teeth?
Yes	No	Do you have “tension” headaches?

Yes No Have you ever experienced chronic ringing in your ears?

Yes No Are you aware that some appointments will be during work hours?

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature:_____

Date:_____