# FOR ADULTS: WELCOME TO OUR PRACTICE

## 1.) ABOUT YOU

Today's date: _____ DOB: _____

**Name:** AGE: _____

Last First Mi (Mr. Mrs. Ms.)

I preferred to be called: _____

Home #: _____

Work #: _____

SS #: _____

DL #: _____

**Home Address:**

Apt#

City State Zip

## 2.) ABOUT YOUR EMPLOYER:

Name: _____

Address: _____

How long have you worked there? _____

Occupation: _____

When & Where are the best times to reach you? _____

Other family members seen by us:

Who may we THANK for referring you? _____

## 3.) SPOUSE INFORMATION:

Name: _____

Employer: _____

WK#: _____

DL#: _____

SS#: _____

DOB:

## DENTAL INFORMATION:

**Previous/Present Dentist:** _____

**Street:** _____

**Phone:** _____ **Last visit:** _____

## 4.) RESPONSIBLE PARTY INFO:

Name: _____

Billing address: _____

City State Zip

WK#: _____ Ext. ____ HM#: _____

Cell #: _____

Email: _____

Employer: _____

DL#: _____

SS#: _____

### Emergency Contact:

Name: _____ Relation:

WK#: Ext. HM#:

## 5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

**Insured's Name:** _____

Relationship to Patient: _____

**Insured's DOB:** _____

**Insured's Employer:** _____

**SS#:** _____

Orthodontic Coverage: YES NO

## SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

Insurance Co. Phone #: _____

Group/Policy # _____

**Insured's Name:** _____

Relationship to Patient: _____

**Insured's DOB:** _____

**Insured's Employer:** _____

**SS#:** _____

Orthodontic Coverage: YES NO

## 6) DENTAL HISTORY

Why have you come to the orthodontist today? _____

Are you currently in pain? Y N

**Your current dental health is:**

Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

**Have you ever had any 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? _____

A day do you brush? _____

Types of bristles? Hard Medium Soft

## 7) 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

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

## 8) Have you ever had any of the following diseases or medical problems?

| | | | |
|---|---|---|---|
| Y N | Prothesis | Y N | History of 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. Fev. | Y N | Artificial Valves |
| Y N | HIV+/AIDS | Y N | Heart surgery/Pacmkr. |
| 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 | Sev./Freq. headaches |
| Y N | Fever blister | Y N | Hi/Lo 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/Radiation tmt. |
| Y N | Emphysema | Y N | Glaucoma |
| Y N | Sinus Probs. | 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.**

**9) 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 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 --- OFFICE USE ONLY --- OFFICE USE ONLY

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

Initials: _____ Date: _____

**Doctor's comments:** _____

**Medical History Update:**

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____