

**ADULT PATIENT INFORMATION**

A B C

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City Zip

Mailing Address \_\_\_\_\_  
Street City Zip

How long at this address? \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Email Address \_\_\_\_\_ Marital Status: Single\_\_ Married\_\_ Widowed\_\_ Separated\_\_ Divorced\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_  
Street City Zip

Phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Signature \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

**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? \_\_\_\_\_  
Female Patients only:
- Yes No Are you pregnant? \_\_\_\_\_
- Yes No Has menstruation started? \_\_\_\_\_

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

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

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