ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

Home phone_____ Work phone_____

Cell Phone_____ Birthdate_____ Email Address_____

Whom 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 Do you experience sleeping problems such as snoring or sleep apnea? _____

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	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	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 also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____