

ADULT PATIENT INFORMATION

Name: Ms.
Mrs.
Mr.
Dr. _____ Prefer to be called: _____ Sex: _____
First Last

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Age: _____ Birthdate: _____ SS#: _____

Occupation: _____ Bus. Address: _____ Bus. Phone: _____

Marital Status: Single Married Divorced Separated Widow(er)

Spouse's Name: Ms.
Mrs.
Mr.
Dr. _____ Occupation: _____ Bus. Phone: _____
First Last

Who will be responsible for this account? _____

Is there dental insurance? _____ Name of Carrier _____

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

Please describe your problem and concerns: _____

What do you expect from treatment? _____

DENTAL HISTORY

General Dentist: _____ Address: _____ Phone: _____

Frequency of dental checkups: Twice a year Once a year Only if a problem arises Never Date of last visit: _____

Is there any unfinished care to be completed with your dentist? No Yes Explain: _____

Have you ever had periodontal (gum) disease? No Yes Explain: _____

Have you had any face or dental injuries? No Yes Explain: _____

Have teeth (either primary or permanent) been removed? No Yes Explain: _____

Have you consulted an orthodontist previously? No Yes Type of treatment: _____

Have you noticed any changes in your bite or dental alignment recently? No Yes _____

Explain: _____

Please check if there is a history of:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Jaw joint popping |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Muscle soreness around head & neck | <input type="checkbox"/> Jaw joint clicking | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Difficulty opening mouth wide | <input type="checkbox"/> Mouthbreathing while: | <input type="checkbox"/> Awake <input type="checkbox"/> Asleep |

Is there any other information that may be helpful? _____

Please Turn Over

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

MEDICAL HISTORY

Physician's Name: _____ Last Visit: _____

Address: _____ 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 received a blood transfusion? No Yes Reason: _____

Have your tonsils or adenoids been removed? No Yes When: _____

Have you been in a risk group for AIDS? No Yes Explain: _____

Please check if you have had any of the following conditions:

Heart Murmur No Yes Hepatitis No Yes Emotional Problems ... No Yes

Heart Surgery No Yes Diabetes No Yes Frequent Headaches . No Yes

Rheumatic Fever No Yes Kidney Disease . No Yes Nervous/Anxious No Yes

Endocrine Disorders No Yes Liver Disease No Yes Cancer No Yes

Prolonged Bleeding No Yes Tuberculosis No Yes Bone Disorders No Yes

Anemia No Yes Bronchitis No Yes Growth Disorders No Yes

Blood Disease No Yes Asthma No Yes Mouth Breather No Yes

Developmental Disorder . No Yes Epilepsy No Yes Herpes (Fever Blisters) No Yes

Hives/Rash No Yes Fainting No Yes Tonsillitis No Yes

Any other health problems or special concerns? _____

Comments: _____

INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services are charged directly to the patient and the patient is responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company.

Patient's Signature

Date