

**WELCOME TO OUR OFFICE**

So that we may become better acquainted, please complete both sides of this form.

**ADULT PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Prefer to be called: \_\_\_\_\_ Sex: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Length at Current Address: \_\_\_\_\_ years \_\_\_\_\_ months Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Patient's Dentist: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Do you know a patient currently in the practice? If so whom?: \_\_\_\_\_  
Who noticed the orthodontic problem?  Patient  Dentist  Both  Other \_\_\_\_\_  
Describe the orthodontic problem in your own words \_\_\_\_\_  
What concerns you most about the thought of orthodontic treatment?  
 Appearance of appliances  Cost  Length of time  Discomfort  Results  Other \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Length at present employer \_\_\_\_\_ Yrs  
Address of employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Address: \_\_\_\_\_

**FAMILY AND ACCOUNT INFORMATION**

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Length at present position \_\_\_\_\_ Yrs  
Work Address \_\_\_\_\_ Wk phone \_\_\_\_\_  
Person responsible for account: \_\_\_\_\_  
*If Other than Self or Spouse:*  
Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Length at present position \_\_\_\_\_ Yrs  
Work Address \_\_\_\_\_ Wk phone \_\_\_\_\_

*In order for our office to offer extended payment plans, we may request a credit report unless you specify otherwise.*

**INSURANCE INFORMATION**

***A dental insurance policy is a contract between the insured and the insurance company. Our services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for all fees incurred. For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with insurance information at your first visit. Otherwise we will assume that you are submitting all claims to your insurance carrier.***

Name of Insured (Employee): \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_ Phone# \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Insured (Employee): \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_ Phone# \_\_\_\_\_ Group # \_\_\_\_\_

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

### MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- Have you experienced any health problems?  No  Yes Explain: \_\_\_\_\_  
 Any major change in your health recently?  No  Yes Explain: \_\_\_\_\_  
 Are you currently taking medication?  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 tested positive for HIV/AIDS?  No  Yes Explain: \_\_\_\_\_  
 Have you ever taken diet medications?  No  Yes List: \_\_\_\_\_

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

- |                |                                                          |                        |                                                          |                         |                                                          |
|----------------|----------------------------------------------------------|------------------------|----------------------------------------------------------|-------------------------|----------------------------------------------------------|
| Heart Murmur   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Surgery          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Fainting                | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hepatitis      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Rheumatic Fever        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nervous/Anxious         | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Endocrine Disorder     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Prolonged bleeding     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone Disorders          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Liver Disease  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Anemia                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Growth Disorders        | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Tuberculosis   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Blood Disorder         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Mouth Breather          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Bronchitis     | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hives/Rashes           | <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes (fever blisters) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Asthma         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Developmental Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tonsillitis             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Epilepsy       | <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |                                                          | Emotional Problems      | <input type="checkbox"/> No <input type="checkbox"/> Yes |
|                |                                                          |                        |                                                          | Frequent Headaches      | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Is there any other condition or problem we should know about? \_\_\_\_\_

Comments? \_\_\_\_\_

### DENTAL HISTORY

Dentist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dental Specialist Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Frequency of dental checkups: Twice a year  Once a year  Only if problem exists  Never   
 Date of last dental visit: \_\_\_\_\_

- Is there any unfinished care to be completed with your dentist?  No  Yes Explain: \_\_\_\_\_  
 Are you frightened about dental treatment?  No  Yes Explain: \_\_\_\_\_  
 Have you had an unpleasant experience in a dental office?  No  Yes Explain: \_\_\_\_\_  
 Have you had any face or dental injuries?  No  Yes Explain: \_\_\_\_\_  
 Do you play a musical instrument?  No  Yes Which one? \_\_\_\_\_  
 Have you consulted an orthodontist previously?  No  Yes With whom? \_\_\_\_\_  
 Have teeth (either primary or permanent) been removed?  No  Yes \_\_\_\_\_  
 Have you had any previous orthodontic treatment?  No  Yes With whom? \_\_\_\_\_  
 Are you satisfied with prior treatment?  No  Yes Explain: \_\_\_\_\_  
 Have you noticed any changes in your bite or dental alignment recently?  No  Yes Explain: \_\_\_\_\_

What are the chief concerns you have related to the position of your teeth or bite:

- Aesthetic  Cleaning  Comfort  Ability to chew  Stability

Please elaborate: \_\_\_\_\_

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

- Wear or fracture of teeth  Difficulty with cleaning related to dental alignment  Bone or gum tissue loss  
 Jaw joint or muscle tightness  Alignment of teeth prior to restorative work (crowns, bridges, etc.)  
 Other \_\_\_\_\_

Please check if there is a history of:

- Clenching  Muscular soreness around head & neck  Jaw joint soreness  Jaw joint popping  
 Grinding teeth  Headaches (more than normal)  Jaw joint clicking  Ringing in the ears  
 Speech problems (If so, which sounds: \_\_\_\_\_)  Mouth breathing: Awake \_\_\_\_\_ Asleep \_\_\_\_\_  
 Tongue thrust habit

Is there any other information that may be helpful? \_\_\_\_\_

Reviewed By \_\_\_\_\_  
 Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_