ADULT PATIENT INFORMATION

Today's Date ____/____/____

ABOUT YOU

Name _____ Nickname_____
LAST FIRST MIDDLE

Birthday _____/_____/_____ Age _____ Male _____ Female _____

Address_____

City _____ State _____ Zip Code _____

Email Address _____

Home # (_____)_____ Cell # (_____)_____

How would you like to be reminded of future appointments? Call _____ Text_____ Email_____

DL # _____ SS # _____

Single ____ Married _____ Partnered _____ Widowed _____ Divorced _____ Separated _____

Employer_____ Occupation _____

Employer's Address _____ Wk # (_____)_____

When is the best time to reach you? _____

Whom may we thank for referring you? _____

SPOUSE INFORMATION

Spouse's Name _____ Birthday _____/_____/_____

Employer_____ Occupation _____

Employer's Address _____ Wk # (_____)_____

Home # (_____)_____ Cell # (_____)_____

DL # _____ SS # _____

EMERGENCY INFORMATION

Relative or friend not living with you:

Name _____ Relation _____

Phone # (_____)_____ Address _____

INSURANCE INFORMATION

Insured's Name _____ Relation _____

Insured's Birthday _____/_____/_____ Insured's SS # _____

Insurance Co. _____ Insurance Address _____

_____ Phone # (_____)_____
CITY STATE ZIP CODE

ID # _____ Group # _____

Insured's Employer (if differs from above) _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insured's Name _____ Relation _____

Insured's Birthday _____/_____/_____ Insured's SS # _____

Insurance Co. _____ Insurance Address_____

_____ Phone # (_____)_____
CITY STATE ZIP CODE

ID # _____ Group # _____

Insured's Employer (if differs from above) _____

I understand that payment is due IN FULL at the time of treatment unless prior arrangements have been approved. I understand that this office reserves the right, when appropriate, to obtain credit bureau

reports of patients and/or parties responsible for the account. I understand that I am responsible for payment of services rendered, as well as any co-payment or deductible that insurance does not cover. I authorize the dentist to release any information necessary to obtain payment of benefits. Furthermore, I directly assign to the doctor all insurance benefits otherwise payable to me.

Signature of Parent or Guardian _____ Date _____/_____/_____

MEDICAL HISTORY

Physician _____ Physician's Phone # (_____)_____

Are you currently under the care of a physician? Yes _____ No _____

If yes, please explain:_____

Describe your current physical health: Good _____ Fair _____ Poor _____

Do you smoke or use tobacco? Yes _____ No _____

Have you had any metal rod, pins or implants? Yes _____ No _____

Have you had any operations? Yes _____ No _____

Have you ever been involved in a serious accident? Yes _____ No _____

All prescription and over the counter drugs you are currently taking: _____

Is the patient allergic to:

Aspirin Yes____ No____	Erythromycin Yes____ No____	Penicillin Yes____ No____
Codeine Yes____ No____	Latex Yes____ No____	Nickel/Metals Yes____ No____
Tetracycline Yes____ No____	Plastic Yes____ No____	Dental Anesthetics Yes___ No___

Any other drugs/things patient is allergic to: _____

Mark X on any of the medical conditions the patient has had or currently has:

Abnormal bleeding/Hemophilia____	AIDS/HIV____	Alcohol/ Drug Abuse____
Artificial Bones/Joints/Valves____	Anemia____	Arthritis____

Asthma____
Blood Transfusion____
Cancer____
Chemotherapy____
Colitis____
Congenital Heart Defect____
Diabetes____
Difficulty Breathing____
Emphysema____
Epilepsy___
Fainting Spells____
Frequent Headaches____
Glaucoma____
Hay Fever____
Heart Attack/Surgery____
Heart Murmur____
Hepatitis/Liver problems____
Herpes____
High Blood Pressure____
Kidney Problems
Low Blood Pressure____
Lupus____
Mitral Valve Prolapse____
Nervous Disorders____
Pacemaker____
Psychiatric Problems____
Radiation Treatment____
Rheumatic Fever____
Seizures____
Shingles____
Stroke____
Sinus Problems____
Sickle Cell Disease____
Thyroid Problems____
Tuberculosis____
Tumor____
Ulcers____
Venereal Disease____

Any medical conditions not listed that the doctor should be aware of?_____

Anything you would like to discuss with the doctor in private? _____

For Women: Are you using prescribed method of birth control? Yes _____ No _____

Are you pregnant? Yes _____ No _____ If yes, week # _____

Are you nursing? Yes _____ No _____

DENTAL HISTORY

General Dentist _____ Dentist's Phone # (_____)_____

Main concerns you would like orthodontic treatment to accomplish? _____

Have you ever been evaluated or had orthodontic treatment before? _____

Have you ever experienced any unfavorable reaction to dentistry? Yes _____ No _____

Has you ever had any pain or tenderness in the jaw joint? Yes ____ No ____

Have your wisdom teeth been removed? Yes _____ No _____

Have you ever had any injuries to the face, mouth or teeth? Yes _____ No _____

If yes, please explain: _____

Do you have any missing or extra permanent teeth? Yes ____ No ____

Do you brush your teeth daily? Yes _____ No _____ Floss daily? Yes _____ No _____

Do you breathe through your mouth? Yes __ No __ If yes, while awake or asleep?_____

Do you have any speech problems? Yes _____ No _____

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 intricate body parts of the body 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 through our lifetime and there can be some movement of teeth and some changes after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for education and promotional purposes. I have truthfully answered all the questions above to the best of my ability and agree to inform the office of any changes in the medical or dental history. In addition, I authorize Dr. Patel to perform a complete orthodontic evaluation.

Signature_____ Date_____/_____/_____

OFFICE USE ONLY

I verbally reviewed the medical/ dental information with the patient named herein.

Signature: _____ Date: _____/_____/_____

Doctor's Comments:_____

_____

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