



Adult Patient Information

Patient Information

Date	
Patient's Name	
Preferred Name/Nickname	
Address	
Birth Date	Age
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary Phone	
Cell Phone	
Work Phone	
Have we treated any other family members? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Names of family members treated	
If patient is a minor, give parent's or guardian's name	

Responsible Party Information

Name	
Address	
How long at this address	
Previous Address (if less than 3 yrs)	
E-Mail Address	
Primary Phone	Cell Phone
Work Phone	Birth Date
Relationship to Patient	
Employer	
Occupation	
No. Years Employed	
Marital status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> partner <input type="checkbox"/> divorced <input type="checkbox"/> widowed	
Spouse/Partner	
Cell Phone	Work Phone
Birth Date	
Relationship to Patient	
Employer	
Occupation	
No. Years Employed	

Orthodontic Insurance Information

Insured's Name	
Birth Date	SSN
Insurance Company	

Orthodontic Insurance Information

Group No.	
Local No.	
Insurance Co Address	
Phone	
Do you have dual coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2nd Insured's Name	
Birth Date	SSN
Insurance Company	
Group No.	
Local No.	
Insurance Co Address	
Phone	

Emergency Information

Emergency Contact Person (not living with you)
Complete Address
Phone

Adult Medical Information

Medical History

Patient's Name				
For the questions check yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.				
Now or in the past has the patient had any of the following: (If yes please explain)				
	yes	no	dk/u	
Birth defects or hereditary problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bone fractures, any major accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid or arthritic conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine or thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer, tumor, radiation treatment or chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach ulcer or hyperacidity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Polio, mononucleosis, tuberculosis or pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS or HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis, jaundice or liver problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting spells, seizures, epilepsy or neurological problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental health disturbance or behavioral problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision, hearing, tasting or speech difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of weight recently, poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
History of eating disorder (anorexia/bulimia)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive bleeding or bruising tendency, anemia or bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Medical History

	yes	no	dk/u
Tires easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, shortness of breath or swelling ankles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches, colds or sore throats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye, ear, nose or throat condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever, asthma, sinus trouble or hives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsil or adenoid conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Allergies or reactions to any of the following:

	yes	no	dk/u
Local anesthetics (Novocaine or Lidocaine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Motrin, Advil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metal (jewelry, clothing snaps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (gloves, balloons)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vinyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acrylic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other substances (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications

	yes	no	dk/u
Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Please list all medications			
Medication	Taken for		
Medication	Taken for		
Medication	Taken for		
Medication	Taken for		
Medication	Taken for		
Medication	Taken for		
	yes	no	dk/u
Do you currently have or ever had a substance abuse problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew or smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operations? Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized? For:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other physical problems or symptoms? Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being treated by another health care professional? For:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of most recent physical exam?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any other medical conditions that we should be aware of:			

Family Medical History

Women Only			
	yes	no	dk/u
Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you planning on becoming pregnant in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your parents or siblings have any of the following health problems? If so, please explain.			
	yes	no	dk/u
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual dental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaw size imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other family medical conditions that we should know about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of Physician		Phone Number	
Location		Last Visit	

Dental Information

Dental History

Patient's Name			
Dentist's Name		Specialist or Other	
What is your primary concern?			
For the questions check yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.			
Now or in the past, has the patient had:			
	yes	no	dk/u
Permanent or "extra" (supernumerary) teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supernumerary (extra) or congenitally missing teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chipped or otherwise injured primary (baby) or permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to hot or cold, teeth throb or ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaw fractures, cysts or mouth infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Dead teeth" or root canals treated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums, bad taste or mouth odor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal "gum problems"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction between teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Gum boils", frequent canker sores or cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal swallowing habit (tongue thrusting)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of speech problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth breathing habit, snoring or difficulty in breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tooth grinding, jaw clenching clicking or locking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any pain in jaw or ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any pain or soreness in the muscles of the face or around the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing or jaw opening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you even been treated for "TMD" or "TMJ" problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thumb, finger, or sucking habit? Until what age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Dental History

	yes	no	dk/u
Aware of loose, broken or missing restorations (fillings)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any teeth irritating cheek, lip, tongue or palate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerned about spaced, crooked or protruding teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aware or concerned about under or over developed jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any relative with similar tooth or jaw relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any wisdom tooth problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had periodontal (gum) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had any serious trouble associated with any previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would you object to wearing orthodontic appliances (braces) should they be indicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a prior orthodontic examination or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current dentist's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush?	Floss?		
I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.			
Patient Signature:			
Date:			