ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Previous Address (If less than 3 years)_____

Cell/Other Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Employer's Address_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Employer's Address _____

Social Security # _____Birthdate _____Work Phone_____

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

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security/ID # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security/ID # _____

Date of Birth_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____

Updates _____ _____ _____ _____ _____ _____ _____ _____

We are happy to provide you with information for your flex plan funding; please give us 6 weeks notice in the event that x-rays are needed. Thank you.

MEDICAL HISTORY

Physician _____ Date of Last Visit_____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

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 surgeries or operations?_____
Yes No Have you ever been involved in a serious accident?_____
Yes No Have you had your tonsils and/or adenoids removed?_____
Yes No Have you ever smoked or chewed tobacco?_____
Yes No Have seen a physician in the last 12 months? Why?_____
Female Patients only:
Yes No Are you pregnant?_____

Circle any of the medical conditions below that you have had or currently have. Please give details on the back of this form.

Abnormal bleeding	Dizziness	HIV/AIDS	Pneumonia
ADD/ADHD	Emotional Problems	Hormonal Imbalance	Prolonged Bleeding
Anemia	Epilepsy	Immune Deficiency	Radiation/Chemotherapy
Arthritis	Gastrointestinal Disorders	Kidney Problems	Rheumatic Fever
Asthma or Hayfever	Heart Murmur	Mental Limitations	Thyroid Problems
Autism (spectrum)	Heart Problems	Migraines	Tuberculosis
Bone Disorders	Hepatitis/Liver Problems	Nervous Disorders	Tumors/Cancer
Cerebral Palsy	Herpes	Neuromuscular Disorder	Ulcers
Diabetes	High Blood Pressure	OCD	Special Needs

Do you have any other medical conditions not mentioned above?_____
_____
Are you presently taking any medications? _____ If yes, what medication and for what condition?_____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit_____
What concerns you most about your teeth?_____

Yes No Are you sensitive or self-conscious about your teeth?_____
Yes No What is your attitude toward receiving orthodontic treatment?_____
Yes No Have you ever seen an orthodontist? If yes, who and when?_____
Yes No Are you a mouth breather?
Yes No Do you have clicking or popping of the jaws?
Yes No Have you ever had any stiffness or soreness of the jaws or jaw muscles?_____
Yes No Are you aware of clenching or grinding your teeth?_____
Yes No Are you aware of your jaw clicking or popping?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have you had any trauma or injuries to the face, mouth, or teeth?_____
Yes No Have you had episodes where the jaw would not open or close normally?_____
Yes No Do you experience “tension” headaches?_____
Yes No Have you ever experienced chronic ringing in the ears?_____
Yes No Have you ever had any unfavorable dental experiences? _____
Yes No Have your wisdom teeth been removed?
Yes No Has anyone in your family received orthodontic treatment?_____
How did they feel about the result?_____
Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning?
Yes No Have you ever been told that you grind your teeth?
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. Martin to perform a complete orthodontic evaluation.

Signature: _____ Date: _____