PATIENT INFORMATION

Date:_____/_____/_____

Patient's name:_____
Last First Middle

Address:_____
Street City Zip

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

Previous Address (If less than 3 years)_____

_____

Cell Phone:_____ Birthdate:_____ SS#:_____

Email Address:_____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employer:_____ Occupation:_____No. years employed_____

Spouse's Name: _____

How did you hear about us?_____

DENTAL INSURANCE INFORMATION

Insured's Name:_____ Insured's Social Security #:_____

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 #:_____

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_____
Date

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

Address_____ Phone_____

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

Yes No Are you taking any medication? _____
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 operations?_____
Yes No Have you ever been involved in a serious accident?_____
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?_____
Yes No Has menstruation started?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____
_____
_____

DENTAL HISTORY

General Dentist_____ Date of last visit_____

What concerns you most about your teeth?_____

Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry?_____
Yes No Have your wisdom teeth been removed?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where?_____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do your gums bleed when you brush?_____
Yes No Do you have any type of thumb or tongue habit?_____

Yes No Are you a mouth breather?_____

Yes No Have you ever seen an orthodontist? If yes, who and when?_____

Yes No What is your attitude toward receiving orthodontic treatment?_____

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 awake in the morning?_____

Yes No Are you aware of your jaw clicking or popping?_____

Yes No Are you aware of clenching your teeth during the day?_____

Yes No Have you ever been told that you grind your teeth?_____

Yes No Do you have “tension” headaches?_____

Yes No Have you ever experienced chronic ringing in your ears?_____

Yes No Are you aware that some appointments will be during work hours?_____

_____

Signature Date