A B C

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 Phone_______________________ Birthdate________________ Social Security # ______________________________

Email Address_____________________ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_______________________________________ Occupation_____________________ No. years employed _____

Spouse's Name____ Relationship to Patient____________________

Employer_______________________________________ Occupation_____________________ No. years employed _____

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 # ___________________

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 ____

Updates (date & initial) ____

MEDICAL HISTORY

Physician ____ Date of Last Visit _________________________

Are you in good health? Yes No

Are you under the care of physician for a specific problem at this time? Yes No Illness: _________________________

Please list any medications you are currently taking and why: ____

Please list any drug allergies or sensitivities: _________________________________

Do you have a history of a serious illness, accident, or operation? Yes No Please Describe: __________________________

Have you ever smoked or chewed tobacco? Yes No For how long? _______________________

Females only: Are you pregnant? Yes No

Please CIRCLE any of the following medical conditions that apply

Diabetes	Epilepsy	Dizziness	Rheumatic Fever	Abnormal Bleeding / Hemophilia
Pneumonia	Arthritis	HIV / AIDS	Ear Infections / Tubes	Prolonged Bleeding
Bone Disorders	Herpes	Asthma	High Blood Pressure	Radiation/Chemotherapy
Heart Murmur	Anemia	Cancer	Rheumatic Fever	Congenital Heart Defect
Heart Problems	Tuberculosis	Kidney problems	Emotional / Nervous Disorders	

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? If Yes, please describe: ______________________________________

Yes No Have you ever lost or chipped any teeth? ____

Yes No Have there been any injuries to your face, mouth, or teeth? __________________________________

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

Yes No Have you had your wisdom teeth removed?

Yes No Are you a mouth breather?

Yes No Do your gums bleed when brushing?

Yes No Is any part of your mouth sensitive to temperature or to pressure? If Yes, where? ________________

Please CIRCLE any of the following that apply

Clenching / Grinding Teeth	Jaw Joint Soreness	Frequent *Tension* Headaches
Jaw Joint Clicking or Popping	Frequent Ringing in the Ears	Head and Neck Muscle Soreness

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

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 Are you open to the idea of permanent teeth being removed if necessary for treatment?

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

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

BENEFITS

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 or change in the position of the teeth after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and 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. Kelly Mitchell & Dr. Brian Bartlett to perform a complete orthodontic evaluation.

Signature : ____Date: _____________________

THANK YOU!