Date: ____________

ADULT NEW PATIENT FORM

Last Name: ____________________ First Name: ___________________ Middle Initial: _____

I prefer to be called: ______________

Birth Date: ____________ Age: ______ Gender: Male □ Female □

Home Address: __________________________________ City/State/Zip: ________________________

Home Phone: ________________________ Cell Phone: ________________________

Email Address: ________________________

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

Occupation: __________________________ Employer: ________________________________

Business Phone No.: ___________________

Who is financially responsible for this account? __________________________

Address (if different from patient): ______________________________________

Phone: _____________________

If you would like the office to file insurance for you, please provide the following information:

Name of Policy Holder: _______________________ Policy Holder's DOB: ______________________

Name of Insurance Company: __________________ Policy Holder's SS #: ____________________

Subscriber ID: _____________________

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

My reason for seeking orthodontic treatment is: ____

Have you had previous orthodontic treatment (please explain)? __________________________________

Please list any other family members treated here and their relationship to you: _____________________

Name of Dentist: _________________________ Phone: _____________________________

Address: _______________________________ City/State/Zip: _______________________________

Date of Last Dental Visit: __________________ Reason for Visit: _______________________________

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Name of Physician: ______________________ Phone: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Date of Last Physician Visit: ________________ Reason for Visit: ______________________________

For the following questions, please mark yes, no, or do not know. All responses are confidential.

MEDICAL HISTORY

Now, or in the past, have you ever had:

Birth defect or hereditary problems?	Yes □	No □	Do Not Know □
Bone fractures or facial trauma?	Yes □	No □	Do Not Know □
Rheumatoid or other arthritic condition?	Yes □	No □	Do Not Know □
Endocrine or thyroid problems?	Yes □	No □	Do Not Know □
Diabetes?	Yes □	No □	Do Not Know □
Cancer, tumor, radiation treatment or chemotherapy?	Yes □	No □	Do Not Know □
Stomach ulcer or hyperacidity?	Yes □	No □	Do Not Know □
Immune system problems?	Yes □	No □	Do Not Know □
HIV/AIDS?	Yes □	No □	Do Not Know □
Kidney problems?	Yes □	No □	Do Not Know □
Hepatitis, jaundice, or other liver problems?	Yes □	No □	Do Not Know □
Mental health disturbances or depression?	Yes □	No □	Do Not Know □
Vision, hearing, tasting, or speech difficulties?	Yes □	No □	Do Not Know □
History of an eating disorder (anorexia, bulimia)?	Yes □	No □	Do Not Know □
Fainting spells, seizures, epilepsy, or other neurological problems?	Yes □	No □	Do Not Know □
Excessive bleeding, bruising, anemia, or bleeding disorder?	Yes □	No □	Do Not Know □
High or low blood pressure?	Yes □	No □	Do Not Know □
Cardiovascular problem (angina, heart attack, coronary insufficiency, arteriosclerosis, heart murmur, or rheumatic heart disease)?	Yes □	No □	Do Not Know □
Chest pain, shortness of breath, or ankle swelling?	Yes □	No □	Do Not Know □
Skin disorder?	Yes □	No □	Do Not Know □
Frequent headaches, colds, or sore throats?	Yes □	No □	Do Not Know □
Asthma?	Yes □	No □	Do Not Know □
Osteoporosis?	Yes □	No □	Do Not Know □
Any condition requiring pre-medication prior to dental procedures?	Yes □	No □	Do Not Know □

Please list any other condition(s) we should know about: ____
____

Have you ever experienced an allergic reaction to any of the following:

Local anesthetics (Novicaine or Lidocaine):	Yes □	No □	Do Not Know □
Aspirin:	Yes □	No □	Do Not Know □
Ibuprofen (Motrin, Advil):	Yes □	No □	Do Not Know □
Penicillin or other antibiotics:	Yes □	No □	Do Not Know □
Sulfa drugs:	Yes □	No □	Do Not Know □
Codeine or other narcotics:	Yes □	No □	Do Not Know □
Metals (jewelry):	Yes □	No □	Do Not Know □
Latex (gloves, balloons):	Yes □	No □	Do Not Know □
Vinyl:	Yes □	No □	Do Not Know □
Acrylic:	Yes □	No □	Do Not Know □

Foods: Yes □ No □ Do Not Know □ If yes, please specify: ________________________________

Other (please specify): ______________________________________

Please list any medications, nutrient supplements, herbal medications, or non-prescription medications.

Medication: ______________________ Taken for: __________________________
Medication: ______________________ Taken for: __________________________
Medication: ______________________ Taken for: __________________________
Medication: ______________________ Taken for: __________________________

Have you ever had a substance abuse problem? Yes □ No □ Do Not Know □
Do you chew or smoke tobacco? Yes □ No □ Do Not Know □

Women Only
Are you pregnant? Yes □ No □ Do Not Know □
Are you anticipating becoming pregnant? Yes □ No □ Do Not Know □

DENTAL HISTORY
Now or in the past, have you ever had:

Permanent or "extra" (supernumerary) teeth removed?	Yes □	No □	Do Not Know □
Supernumerary (extra) or congenitally missing teeth?	Yes □	No □	Do Not Know □
Chipped or otherwise injured primary (baby) or permanent teeth?	Yes □	No □	Do Not Know □
Teeth sensitive to hot or cold?	Yes □	No □	Do Not Know □
Jaw fractures, cysts, or mouth infections?	Yes □	No □	Do Not Know □
"Dead teeth" or root canal treated teeth?	Yes □	No □	Do Not Know □
Bleeding gums, bad taste, or mouth odor?	Yes □	No □	Do Not Know □
Periodontal "gum" problems?	Yes □	No □	Do Not Know □
Treatment for periodontal (gum) problems?	Yes □	No □	Do Not Know □
Food impaction between teeth?	Yes □	No □	Do Not Know □
Frequent canker or cold sores?	Yes □	No □	Do Not Know □
Thumb or finger sucking habit? Yes □ No □ Do Not Know □ If yes, until what age? ______			
History of speech problems?	Yes □	No □	Do Not Know □
Mouth breathing, snoring, or difficulty breathing?	Yes □	No □	Do Not Know □
Tooth grinding or jaw clenching?	Yes □	No □	Do Not Know □
Pain, clicking, or locking of the jaws?	Yes □	No □	Do Not Know □
Pain or soreness of the muscles of the face or around the ears?	Yes □	No □	Do Not Know □
Difficulty with chewing or jaw opening?	Yes □	No □	Do Not Know □
Treatment for "TMD" or "TMJ" problems?	Yes □	No □	Do Not Know □
Any teeth irritating cheek, lip, tongue, or palate?	Yes □	No □	Do Not Know □
Concerns about spaced, crooked, or protruding teeth?	Yes □	No □	Do Not Know □
Concerns about over or underdeveloped jaw?	Yes □	No □	Do Not Know □
Any relative with similar tooth or jaw relationships?	Yes □	No □	Do Not Know □
Any wisdom tooth problems?	Yes □	No □	Do Not Know □
Serious trouble associated with any previous dental treatment?	Yes □	No □	Do Not Know □
Would you object to wearing orthodontic appliances (braces) should they be indicated?	Yes □	No □	Do Not Know □

How often do you brush: _____________ Floss: ___________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

____

Signature of adult patient Date

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