Adult Patient Information

Name (Last, First):

Gender: Male ☐ Female ☐ **Birthdate:**

Street Address:

Primary Number: **Cell Number:**

Email Address:

General Dentist:

What concerns you most about your teeth?

Have you had an orthodontic evaluation before?

Which method(s) would you prefer to receive notifications for future appointments? Email ☐ Text ☐ None ☐

Whom may we thank for referring you to our office?

Billing Party Information
(Person financially responsible if separate from self)

Please select: Dr. ○ Mr. ○ Mrs. ○ Ms. ○

Billing Party's Name (Last, First):

Billing Party's Gender: Male ☐ Female ☐ **Billing Party's Birthdate:**

Billing Party's Social Security Number:

Billing Party's Address:

Billing Party's Primary Number: **Billing Party's Cell Number:**

Billing Party's Work Number: **Billing Party's Email Address:**

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

Relationship to Patient: Spouse ○ Mother ○ Father ○ Aunt ○ Uncle ○ Grandmother ○ Grandfather ○

Occupation: **Employer:** **Number of years employed:**

Dental Insurance Information

If you have dental insurance, please provide the following information so we can verify your benefits before your scheduled appointment.

Primary Insurance Policy Coverage:

Policy Holder's Name (Last, First): **Policy Holder's Date of Birth:**

Policy Holder's Social Security Number: **Policy Holder's Contract Number:**

Employer's Name:

Insurance Company: **Group or Local Number:**

Insurance Company Phone Number and Address (where to mail claims to):

Medical History

Physician's Name (Last, First):

Physician's Phone Number: **Date of Last Visit:**

Describe what is your current health status?

Select any of the following medical/health concerns? (Check all that apply past/present)

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Artificial Bones/ Joints/ Valve
- ☐ Asthma / Arthritis
- ☐ Attention Deficit Disorder
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficult Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy/ Seizures / Fainting
- ☐ Fever Blisters / Herpes
- ☐ Handicap / Disabilities
- ☐ Heart Attack / Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High / Low blood Pressure
- ☐ HIV+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Menstruation
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Puberty
- ☐ Radiation Treatment
- ☐ Rheumatic/ Scarlet Fever
- ☐ Severe / Frequent Headaches
- ☐ Sickle Cell Disease/ Traits
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ TMD
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Ulcers/ Colitis
- ☐ No Medical Con

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Any Metals / Plastics
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other (Please indicate in the in the entry below)

Please list any medications that you are currently taking:

Any of the following dental concerns? (Check all that apply)

- ☐ Have you sucked thumb or fingers as a child?
- ☐ Do you breathe predominantly through the mouth?
- ☐ Do you have any speech problems?
- ☐ Do you clench or grind teeth (at night)?
- ☐ Do you have pain or clicking upon closing the mouth?
- ☐ Any head or face injuries?
- ☐ Have any teeth been chipped due to accidents?
- ☐ Have you been informed of missing permanent teeth?
- ☐ Have you been informed of any extra teeth?
- ☐ Were any teeth (baby or permanent) removed by extraction?
- ☐ Any noticeable difficulty in chewing or swallowing food?
- ☐ Do you bite/suck your lips?
- ☐ Does you have Temporomandibular Joint Disorders?
- ☐ None

Do you brush daily? How many times per a day?

Do you floss daily? How many times per a day?

Have you had your tonsils / adenoids removed? If so when?

Discuss any other medical problems you may have:

Emergency Contact Information

In case of an emergency, please provide the name of the nearest relative not living with you:

Emergency Contact's Name (Last, First):

Emergency Contact's relationship to patient:

Emergency Contact's Phone Number:

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status and updates to my account. I authorize the dental staff to perform the necessary dental service I may need. I understand that I am responsible for payment of services rendered at this office. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Please sign and date:_____