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Diplomate of the American Board of Orthodontics
Member of the American Association of Orthodontists, Southwestern Society of Orthodontists, & World Federation of Orthodontists

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Date: ________________________

PATIENT INFORMATION (Adult)

Patient's Name: ____ SSN: ______________________

Age: _______ Birth date: __________________ Sex: _____ Marital Status: __________________

If married, spouse's name: ____

Home Address: ____
Street City State Zip Code

Home Phone: __________________________ Cell Phone: __________________________

E-Mail Address: ____

Patient's employer: ______________________ Work phone ______________________ Years: ____

Spouse's employer: ______________________ Work phone: ______________________ Years: ____

Special interest(s) of the patient: ____

Chief concern regarding the patient's teeth: ____

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________ Relation: ______________________ SSN: ______________________

Home Address: ____
Street City State Zip Code

Home Phone: __________________ Cell Phone: __________________ Work Phone: __________________

Is patient covered by insurance for orthodontic treatment? YES NO - If yes, please fill out the following:

Insurance co. name__________________________ Insured's name__________________________

Insurance co. address__________________________ Relationship to patient__________________________

Insurance co. phone__________________________ Insured's birthday__________________________

Group #__________________________ Insured's employer__________________________

Insured's ID# or SS#__________________________

PERSON TO BE CONTACTED IF PATIENT / PARENT CANNOT BE REACHED

Name: ______________________________ Relation: ______________________

Address: ____

Home Phone: __________________ Cell Phone: __________________ Work Phone: __________________

MISCELLANEOUS

Family Dentist: ____

Family Physician: ____

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

I hereby certify that all information on this form is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in medical status. I also understand that all information on this form is held in the strictest confidence.

Signature: ____ Date: ______________________

Patient's Name: ______________________________ **Date:** ____________________

PATIENT MEDICAL HISTORY (Adult)

Is patient in good health? .... Yes No
Does patient have any history of major illness? .... Yes No
Has patient ever been under the care
of a physician for illness?........................... Yes No
Please explain any pertinent medical history

____
____
____

Does patient wear contact lenses? .... Yes No
Does patient gag easily? .... Yes No

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

Please indicate with (Y) Yes or (N) No

Y	N		Y	N		Y	N		Y	N	
__	__	Heart problems	__	__	Glaucoma	__	__	Hepatitis or Liver problems	__	__	Sinus Problems
__	__	High blood pressure	__	__	Pneumonia	__	__	Kidney Problems	__	__	Stroke
__	__	Low blood pressure	__	__	Tuberculosis	__	__	Measles	__	__	Typhoid Fever
__	__	Circulatory problems	__	__	Epilepsy	__	__	Mumps	__	__	Tonsillitis
__	__	Nervous disorders	__	__	Arthritis	__	__	Psychiatric Care	__	__	Endocrine problems
__	__	Radiation Treatments	__	__	Asthma	__	__	Rheumatic Fever	__	__	Ulcers
__	__	Excessive Bleeding or Anemia	__	__	Diabetes	__	__	Scarlet Fever	__	__	HIV / AIDS
						__	__	Malignancies	__	__	Other ____________

__ __ Currently pregnant? If yes, how many months? ____________

List any allergies: ______________________________

What medications are now being taken? Please give reasons: ______________________________

____
____

Does patient have a tendency to colds? Yes_____ No_____ Sore throats? Yes_____ No_____ Ear infections? Yes_____ No______

Have tonsils and adenoids been removed? Yes_____ No_____ What age? ________

Date of last physical exam? ______________________________

PATIENT DENTAL HISTORY

Date of last dental exam? ____________ Last dental cleaning? ____________

	Yes	No
Have there ever been any injuries to the face, mouth or teeth?	_____	_____
Has patient ever sucked fingers or thumb? Until what age?	_____	_____
Does patient have any speech problems?	_____	_____
Does patient grind teeth? While awake	_____	_____
While asleep	_____	_____
Is patient a mouth breather? While awake	_____	_____
While asleep	_____	_____
Has patient been informed of any missing or extra permanent teeth?	_____	_____
Has patient consulted an orthodontist previously?	_____	_____
Did either parent have orthodontic treatment?	_____	_____
Does patient have pain in the jaw joints?	_____	_____
Right__________ Left__________		
Does patient have popping or cracking of the jaw joints?	_____	_____
Right__________ Left__________		

When did this begin? ______________________________
Does patient have headaches? ____________ Frequency____________ Location ____________

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Signature: ______________________________ Date: ____________________