

# FOR ADULTS: WELCOME TO OUR PRACTICE

## 1) ABOUT YOU

Today's date: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ AGE: \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ MI (Mr. Mrs. Ms.)

I preferred to be called: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_

SS #: \_\_\_\_\_

DL #: \_\_\_\_\_

Home Address: \_\_\_\_\_

Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## 4) RESPONSIBLE PARTY INFO:

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

WK#: \_\_\_\_\_ Ext. \_\_\_\_\_ HM #: \_\_\_\_\_

Employer: \_\_\_\_\_

DL #: \_\_\_\_\_

SS #: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

WK # \_\_\_\_\_ Ext. \_\_\_\_\_ HM #: \_\_\_\_\_

## 2) ABOUT YOUR EMPLOYER:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

Occupation: \_\_\_\_\_

When & Where are the best times to reach you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Who may we THANK for referring you? \_\_\_\_\_

## 3) SPOUSE INFORMATION:

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

WK #: \_\_\_\_\_

DL #: \_\_\_\_\_

SS #: \_\_\_\_\_

DOB: \_\_\_\_\_

### DENTAL INFORMATION:

Previous/Present Dentist: \_\_\_\_\_

Street: \_\_\_\_\_

Phone: \_\_\_\_\_ Last Visit: \_\_\_\_\_

## 5) PRIMARY DENTAL INSURANCE

Ins. Name: \_\_\_\_\_

Ins. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

SS #: \_\_\_\_\_

Orthodontic Coverage: YES NO

### SECONDARY DENTAL INSURANCE

Ins. Name: \_\_\_\_\_

Ins. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

SS #: \_\_\_\_\_

Orthodontic Coverage: YES NO

**6) DENTAL HISTORY**

Why have you come to the  
orthodontist today?

Are you currently in pain? Y N

Your current dental health is:

Good Fair Poor

Have you ever had a serious/difficult problem  
associated with previous dental work? Y N

Have you ever had any pain or  
tenderness in the jaw joint (TMJ/TMD)?  
Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? \_\_\_\_\_

A day do you brush? \_\_\_\_\_

Types of bristles? Hard Medium Soft

**7) MEDICAL HISTORY**

Do you have a personal physician? Y N

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Last Visit? \_\_\_\_\_

Your current physical health is:

Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain: \_\_\_\_\_

Are you taking any prescription drugs? Y N

**FOR WOMEN ONLY:**

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: \_\_\_\_\_

Are you nursing? Y N

**8) Have you ever had any of the following diseases or medical problems?**

Y N Prosthesis Y N History of Scarlet Fever

Y N Heart Attack Y N Congenital Heart Def.

Y N Cancer Y N Convulsions/Epilepsy/  
Seizure

Y N Diabetes Y N Abnormal Bleeding

Y N Rhuem. Fev. Y N Artificial Valves

Y N HIV+/AIDS Y N Heart surgery/Pacmkr.

Y N Hemophilia Y N Any Stays in Hospital

Y N Asthma Y N Kidney/Liver Problems

Y N Hepatitis Y N Mitral Valve Prolapse

Y N Tuberculosis Y N Artificial bones/joints

Y N Shingles Y N Sev./Freq. headaches

Y N Fever blister Y N Hi/Lo blood pressure

Y N Venereal dis. Y N Drug/Alcohol Abuse

Y N Ulcers/Colitis Y N Blood Transfusion

Y N Heart Murm. Y N Anemia/Radiation tmt.

Y N Emphysema Y N Difficulty breathing?

Y N Sinus Probs.

Y N Glaucoma

Other physical or psychological issues?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you allergic to any of the following?**

Y N Aspirin Y N Erythromycin

Y N Codeine Y N Dental Anesthetics

Y N Latex Y N Tetracycline

Y N Penicillin Y N Other: \_\_\_\_\_

9) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.

**OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY**

I verbally reviewed the medical/dental  
information above with the parent/guardian &  
patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History Update:**

1. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

2. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.