ADULT
Patient Information

Patient's Name__________ Preferred Name__________ □ Male □ Female
Address__________ City__________ State_____ Zip_____
Birthdate_____ Age_____ General Dentist__________ Date of last checkup?_____
Hobbies/Special Interests__________
Whom may we thank for recommending our office to you?__________
Have any family members had orthodontic treatment?__________

Responsible Party Information

Marital status: □ Married □ Separated □ Divorced □ Widowed □ Single
Person responsible for account (if other than above patient)__________ Relationship to patient_____
Address__________ City__________ State_____ Zip_____
No. Years at this address?_____ Previous address (if less than 3 yrs.)__________
Home Phone__________ Cell Phone__________ Cell Carrier_____
Work Phone__________ Ext_____ Email__________
Preferred Correspondence (check all that apply): □ Mail □ Email □ Text SS#__________ Birthdate_____
Employer__________ Occupation__________ No. Years Employed_____

IF MARRIED:
Spouse's Name__________ Spouse's Employer__________
No.Years Employed_____ Occupation__________ SS#__________ Work Phone_____
Are you covered by orthodontic insurance? □ Yes No

Emergency Information

Name of nearest relative not living with you__________ Relationship_____
Address__________ City__________ State_____ Zip_____
Home Phone__________ Cell Phone__________

Health History

Are you in good health? □ YES □ NO Explain:__________
Any major or unusual illnesses? □ YES □ NO Explain:__________
Are you under a physician's care? □ YES □ NO Reason:__________
Are you currently taking medication? □ YES □ NO Reason:__________
Have you ever taken Bisphosphonate medication
for bones (such as Fosamax, Actonel, Boniva)? □ YES □ NO List:__________
Allergies? □ YES □ NO List:__________
Drug sensitivity? □ YES □ NO List:__________

Please check box if patient currently has, or has a history of any of the following:

□ Adenoiditis
□ Anemia
□ Asthma
□ ADHD/hyper activity
□ Blood Disease
□ Bone disorders
□ Diabetes
□ Endocrine Problems
□ Epilepsy
□ Fever blisters/Herpes
□ Glaucoma
□ Handicaps/Disabilities
□ Heart problems
□ Hepatitis
□ HIV (tested positive)/AIDS
□ Joint Surgery/Replacement
□ Latex Allergy
□ Tobacco use
□ Osteoporosis
□ Tuberculosis
□ Frequent Colds or Flu
□ Removal of tonsils: Age: _____
□ Removal of adenoids: Age:_____
□ Mouthbreathing: While awake?_____
While asleep?_____

Dental History

Have you ever had any severe head or face injuries? □ Yes No If so, explain:__________
Have you had a history of thumb sucking or finger sucking? □ Yes No If so, have you stopped sucking?_____ When?_____
Do you play any musical (wind) instruments? □ Yes No If so, what?__________
Have you consulted with an orthodontist previously? □ Yes No If so, who?__________
Have you had any previous orthodontic treatment? □ Yes No If so, when?__________
Have any family members had orthodontic treatment? □ Yes No If so, who?__________

Please check box if patient has a history of any of the following:

□ Clenching Teeth
□ Grinding Teeth
□ Muscular Soreness around Head and Neck
□ Headaches (more than normal)
□ Ringing in the ears
□ Jaw Joint Popping
□ Jaw Joint Soreness
□ Jaw Joint Clicking

Responsible Party's Signature:__________ Date:_____
**I understand that where appropriate, credit bureau reports may be obtained.*

Updates (date & initial) _____ _____ _____ _____ _____ _____ _____