OWENS-BAKER
ORTHODONTICS

Adult Patient Information

Patient Name:_____ Preferred Name_____ □ Male □ Female

Address:_____ City:_____ State:_____ Zip:_____

Birthdate:_____ Age:_____ SS#_____ General Dentist_____

Date of last checkup?_____ Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Carrier:_____ Email:_____

Employer:_____ Occupation:_____ Yrs Employed:_____

Preferred Correspondence: □ Mail □ Email □ Text

Hobbies/Special Interests_____

Whom may we thank for recommending our office to you?_____

Have any family members had orthodontic treatment?_____ If so, who?_____

Responsible Party Information

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

Person Responsible for Account (Fill out ONLY IF DIFFERENT from above patient information)

Name:_____ Birthdate:_____ SS#_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Cell Carrier:_____ Email:_____

Employer:_____ Occupation:_____ Yrs Employed:_____

Preferred Correspondence: □ Mail □ Email □ Text

IF MARRIED:

Spouse's Name:_____ Employer:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Dental Insurance Information

Subscriber's Name:_____ DOB:_____ ID or SS#_____

Subscriber's Address:_____

Employer:_____ Insurance Co. Name:_____

Insurance Phone#_____ Relationship to Patient:_____

Emergency Contact Information

Emergency Contact Name:_____ Relationship_____

Home Phone:_____ Cell Phone:_____

Adult - 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:_____

Allergies? □ YES □ NO List:_____

Drug sensitivity? □ YES □ NO List:_____

Have you ever taken Bisphosphonate medication for bones (such as Fosamax, Actonel, Boniva?) □ YES □ NO List:_____

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

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

□ Mouthbreathing: While awake?_____ While asleep?_____

Dental History

Have you 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?_____ 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?_____

By whom?_____

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

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

Smile Questionnaire

To evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all that apply):

Too small or short?	NO	YES
Too large or long?	NO	YES
Crooked or crowded?	NO	YES
Misshaped (uneven/pointed?	NO	YES
Off Color?	NO	YES

Do you feel your front teeth "stick out too much" (buck teeth)? NO YES

Are there spaces between your teeth that you do not like? NO YES

Does too much or too little gum tissue show when you smile? NO YES Explain:_____

What are your chief concerns that you want orthodontics to address? Please indicate your goals and expectations of orthodontic treatment. (Explain in detail)_____

_____

_____

Responsible Party's Signature:_____ Date:_____