Patient Information Form / Adult

Welcome to our office! Please assist us by completing the following questions: Date of Exam: _____

Patients Name: _____ Birthdate: _____ Age: _____ Sex: _____

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

Email address: _____ Home Phone: _____ Cell: _____

Appointment reminder preference (circle one): Text E-mail Phone

Marital Status (circle one): Single Married Separated Divorced Remarried Widowed

Dentist: _____ Physician: _____ Who suggested our office? _____

Name of other family members treated by our office: _____

Employed by: _____ Occupation: _____ Cell phone: _____

Spouse/ Partner name: _____ Employed by: _____ Cell phone: _____

Insurance: □ Orthodontic □Dental only □ No Insurance

Insured's name: _____ Birthdate: _____ SSN: _____

Insurance Co: _____ Phone #: _____ Group #: _____

(If Dual:)

Insured's name: _____ Birthdate: _____ SSN: _____

Insurance Co: _____ Phone #: _____ Group #: _____

Medical History

Have you ever had an illness due to any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart trouble	__	__	Anemia	__	__	Thyroid	__	__	Arthritis of any kind	__	__
Blood pressure	__	__	Epilepsy	__	__	Bone disorders	__	__	Positive HIV Virus (AIDS)	__	__
Rheumatic fever	__	__	Asthma	__	__	Liver (Hepatitis)	__	__	Neurologic disorders	__	__
Prolonged bleeding	__	__	Kidneys	__	__	Diabetes	__	__	Fainting/Dizziness	__	__

Are you presently in good health? _____

Is there any medical problem (or history of) that we should be aware of? _____

List any allergies or drug sensitivities_____

List any drugs/medications now being taken. Give reasons_____

Dental History **Circle Yes or No (if yes explain your answer)**

Have you ever injured your teeth, mouth or jaw? **Yes** **No** Explain_____
Are any teeth especially sensitive? **Yes** **No** Explain_____
Do your jaw joints make noises (clicking, popping, or grating sounds)? **Yes** **No** Explain_____
Do your jaws ever "lock" or get stuck? **Yes** **No** Explain_____
Do you occasionally feel pain in front of, behind, or in your ears? **Yes** **No** Explain_____
Do you have problems when you chew or open wide? **Yes** **No** Explain_____
Do you often feel tension or spasms in your head or neck? **Yes** **No** Explain_____
Do you think stress or nervous tension affects this problem? **Yes** **No** Explain_____
Do you suffer from headaches in the morning, noon or afternoon? **Yes** **No** Explain_____
Have you had a previous orthodontic examination? **Yes** **No** Explain_____
When did you last see your dentist?_____ Were X-rays taken? **Yes** **No**
What is the reason for today's examination?_____

I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of service unless other arrangements have been made. I understand my credit information may be obtained. I authorize the dental staff to perform any necessary dental services that I may need.

_____

Patient Signature Date