



New Patient Form – Adults

(Please fill, save, print and bring with you)

GENERAL INFORMATION

Today's Date:

Patient's Name: Date of Birth:

Age: Male Female Social Security Number:

Home Address:

Home Phone #: Cell Phone #:

E-mail Address: Would you like to receive email confirmation? Yes No

Employer: Occupation:

Business Address:

Work Phone #:

How did you hear about us?

MAIN CONCERNS/REASONS FOR DESIRING ORTHODONTICS?

Person responsible for Payment:

MARITAL STATUS: Single Married Divorced Widowed Other

Spouse's Name: Date of Birth:

Home Phone: Cell phone: Work Phone:

E-mail Address: Would you like to receive email confirmation? Yes No

Business Address:

Names and Ages of Children: Name: Age:

Name: Age:

Name: Age:

Names of other family members seen by us: Name:

Name:

Name:



DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name:

ID #: Group #: Insurance Co. Phone #:

Insurance Co. Address:

Insured's Name: Relationship:

Insured's Birthdate: Insured's Social Security #:

Insured's Employer:

Secondary Insurance

Insurance Co. Name:

ID #: Group #: Insurance Co. Phone #:

Insurance Co. Address:

Insured's Name: Relationship:

Insured's Birthdate: Insured's Social Security #:

Insured's Employer:

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature: _____

Updates: Date: Initial:



MEDICAL HISTORY

Physician:

Last Visit Date: Office Phone #:

Address:

Do Any Of The Following Apply To You ?

- Yes No Allergies (Latex/Medications/Food) Please specify:
- Yes No Anemia (Type:)
- Yes No Hemophilia / Abnormal Bleeding
- Yes No Blood transfusion
- Yes No Cancer / Radiation/Chemotherapy
- Yes No High / Low Blood Pressure
- Yes No Diabetes (Type:)
- Yes No Epilepsy / Seizures / Fainting Spells
- Yes No Severe / Frequent Headaches
- Yes No Bone Disorders
- Yes No Artificial / Replacement Joints
- Yes No Arthritis
- Yes No HIV+ / AIDS
- Yes No Kidney Problems
- Yes No Hepatitis (Type:)
- Yes No Gastrointestinal Disorders:
- Yes No Smoking
- Yes No Drug / Alcohol Abuse
- Yes No Fever Blisters / Herpes
- Yes No Pregnant (presently)
- Yes No Any Cardiac Conditions (Congenital Heart Defects, Artificial Valves, Rheumatic/Scarlet Fever, Heart Surgery, Pacemaker, Heart Attack, Stroke, Heart Murmur)
- Yes No Any Respiratory Conditions (Asthma, Sinus Issues, Tuberculosis, Tonsil or Adenoid Removal)
- Yes No Any neurological/psychological/emotional/developmental conditions (hypersensitivity, ADHD, ADD, Autism etc.)
- Yes No Have you been hospitalized for any reason?
- Yes No Are you currently under care of a physician?
- Yes No Have you taken any Bisphosphonate Preparations (Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa)
- Yes No Are you taking any medication? Please list all

Are there any medical conditions we have not discussed that you feel we should be aware of?



DENTAL HISTORY

Family Dentist:
Last Visit Date: Office Phone #:
Address:

Do Any Of The Following Apply To You ?

Yes No Any Habits like thumb sucking, lip sucking Or Biting, tongue thrusting, Nail Biting, Mouth Breathing
If YES please Specify
 Yes No Have you ever experienced locking? (Open lock or closed lock) OR any limited range of motion
 Yes No Do you clench / grind teeth?
 Yes No Have you ever experienced pain / discomfort in the jaw joint (TMJ)?
If YES, are you currently being treated for the above?
Any injuries to the: Face Mouth Teeth Chin
 Yes No Have you ever been diagnosed with Gingival (Gum) Disorder?
 Yes No Do you need to be pre-medicated with an antibiotic prior to invasive dental procedures that will cause
bleeding because of a heart problem?
Have you ever experienced any unfavorable reaction to dentistry?
Are there any other dental conditions we have not discussed that you feel we should be aware of?

ORTHODONTIC HISTORY

Yes No Have you had previous orthodontic treatment?
 Yes No Have you consulted another orthodontist?
 Yes No Do you have any other family member(s) that are currently being treated orthodontically?
If YES, please list and explain:
Are you aware that some appointments may be during work hours?

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the dental staff to perform any dental services that I may need during the diagnosis and treatment with my informed consent

Signature: _____ Date: