Adult History

Today's Date: ________________

Name: ____
Last First MI MR MRS MS DR

I prefer to be called: _____________________________ ☐ Male ☐ Female Birthdate ____/____/_____ Age: ___________

Home address: ____

City ____State __________ Zip _______________

Home#: ______________________Cell#: ________________________E-Mail: _____________________________________

Would you like text reminders? ☐ Yes ☐ No Would you like email reminders? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer: ____Work# __________________________________

Occupation: ____

Orthodontic Insurance

Name of Insurance Co.: ____Phone #: ___________________________________

Address: ____

Subscriber I.D.#: ______________________________________Group #: ____

Subscriber Name: ______________________________ SS# _________________________ DOB: ______________________

Employer Name: ____

Secondary Insurance: ____ Phone#: ________________________________

Address: ____

Subscriber I.D.#: ______________________________________ Group #: ____

Subscriber Name: ______________________________ SS# _________________________ DOB: ______________________

Employer Name: ____

Dental & Medical History

General Dentist ____ Date of Last Cleaning: ____________________

Whom may we thank for referring you to our office? ____

What are the main concerns that you would like orthodontics to accomplish? _______________________________

____

Have you ever had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had any injuries to the face, mouth, teeth, or chin? ☐ Yes ☐ No

Please describe: ____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you require pre-medication prior to dental visits? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____

Please list medications you are currently taking:____

Please list any medications/foods that you are allergic to: _______________________________________

____

Have you ever been diagnosed with any of the following diseases/medical problems? (Please check all that apply)

____Abnormal bleeding
____Asthma
____Bleeding Gums
____Blood Pressure (high/low)
____Cancer
____Convulsions/Epilepsy
____Diabetes
____Headaches/pain of face & head
____Hearing Impairment
____Heart Disease
____Heart Murmur
____Hepatitis
____HIV+/Aids
____Kidney/Liver Problems
____Osteoporosis
____Rheumatic/Scarlet Fever
____Tuberculosis
____Clenching/Grinding teeth
____Mouthbreather
____Smoker
____Tongue Thrust

____Other? Please describe:____

If female, are you pregnant? ☐ Yes ☐ No Week #:_______

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature ____ Date _____________