Adult Patient Confidential Information

Patient's Name_____
First Middle Last

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Birthday_____ Male___ Female___

Hobbies/Interests_____

Dentist Name_____ Referral By_____

Confidential Billing Information

Name_____ Marital Status_____
Mr. Ms. Mrs. Rev., Dr. First Initial Last

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Email Address_____

Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Mr. Ms. Mrs. Rev., Dr. First Initial Last

Employer_____ Occupation_____ Years Employed_____

Dental Insurance Information

Policy Holder's Name_____ Relationship to Patient_____
Mr. Ms. Mrs. Rev., Dr. First Initial Last

Policy Holder's Address if Different From Patient_____
Street City State Zip

Insurance Company Name_____ Insurance Company Phone_____

Insurance Company Address_____

Subscriber ID Number_____ Subscriber Birth Date_____

Subscriber Employer_____ Group Number_____

Secondary Dental Insurance Information

Policy Holder's Name_____ Relationship to Patient_____
Mr. Ms. Mrs. Rev., Dr. First Initial Last

Policy Holder's Address if Different From Patient_____
Street City State Zip

Insurance Company Name_____ Insurance Company Phone_____

Insurance Company Address_____

Subscriber ID Number_____ Subscriber Birth Date_____

Subscriber Employer_____ Group Number_____

What are your main orthodontic concerns?_____

_____

Please circle Y for Yes or N for No

Do you require antibiotic pre-medication for dental procedures?	Y	N
Have you ever been evaluated for or had orthodontic treatment?	Y	N
Have there been any injuries to the face, mouth, teeth or chin?	Y	N
Have adenoids or tonsils been removed?	Y	N
Have you been informed of any missing or extra permanent teeth?	Y	N
Have you had any pain/tenderness in your jaw joint (TMJ/TMD)?	Y	N
Do you brush/floss your teeth daily?	Y	N
Have you ever received or had recommended periodontal (gum) treatment	Y	N

Medical Information

Physician's Name_____Phone_____

Date of last physical_____ Are your immunizations up to date? Yes No

Are you presently being treated for any condition? Yes No Explain_____

Have you ever been diagnosed as having any of the following conditions? **Please circle Y for yes or N for No**

Y N Abnormal bleeding/bruising	Y N Chronic ear infections	Y N Hepatitis or liver disease
Y N AIDS or HIV	Y N Congenital heart disease	Y N Hyperactivity/ADD/ADHD
Y N Allergies	Y N Convulsions or seizures	Y N Kidney/liver disease
Y N Allergies to drugs	Y N Diabetes	Y N Nutritional deficiency
Y N Allergic to latex/metals	Y N Excessive gagging	Y N Oral ulcers
Y N Asthma	Y N Growth & development problems	Y N Rheumatic fever
Y N Cancer	Y N Hearing/speech problems	Y N Tuberculosis
Y N Chronic adenoid/tonsil infections	Y N Heart Murmur	Y N Other_____
Y N Chronic headaches	Y N Hemophilia	Y N Blood transfusions

Please discuss any medical problems that you have had_____

_____

Please list all drugs that you are currently taking_____

Please list all drugs that you are allergic to_____

Do you/did you have any of the following habits?

Y N Clenching/grinding teeth	Y N Tongue thrust
Y N Nail biting	Y N Lip sucking/biting
Y N Mouth breathing	Y N Thumb/finger sucking

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the orthodontic staff to perform the necessary orthodontic services.

Signature of patient _____Date_____

I verbally reviewed the medical/dental information above with the the patient named herein. Initials_____Date_____