

Adult New Patient Information Form

Patient Information		
I prefer to be called		Date of Birth
Title <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss. <input type="checkbox"/> Dr. <input type="checkbox"/> Other		Social Security #
First Name	Last Name	Middle Initial
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
City, State, Zip Code		
Cell phone () -	Home phone () -	Work phone () -
Email Address		Preferred method of contact <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email
Occupation	Employer	
Whom may we thank for referring you?		
Closest Relative		
Spouse or closest relative's name(s)		Relationship to patient
Address (if different than patient address)		
City, State, Zip Code		
Cell phone () -	Home phone () -	Work phone () -
Emergency Contact		<input type="checkbox"/> Check here if same as above
Emergency contact		Relationship to patient
Cell phone () -	Home phone () -	
Financial Responsibility		
Who is financially responsible for this account?		Relationship to patient
Social Security #	Cell phone () -	Home phone () -
Email Address	Employer	
Address (if different from page 1)		City, State, Zip
Who will be responsible for bringing the patient to orthodontic appointments?		
Dental Insurance		<input type="checkbox"/> Check here if no orthodontic coverage will be applied
Primary policy holder's full name		Relationship to patient:
Social Security #	Birthdate	
Address and phone (if not listed above)		
Insurance company		Insurance phone #
Employer/Group Name	Group #	ID #
Does this policy have orthodontic benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Dental Insurance		<input type="checkbox"/> Check here if no secondary insurance
Primary policy holder's full name		Relationship to patient:
Social Security #	Birthdate	
Address and phone (if not listed above)		
Insurance company		Insurance phone #
Employer/Group Name	Group #	ID #
Does this policy have orthodontic benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		

Medical History

Physician _____ Phone _____ Date of last exam _____

1. Are you under medical treatment now? Yes No
2. Have you been hospitalized for any surgical operations or serious illness in the past five years? Yes No
3. Are you taking medication(s) including non-prescription medicine? Yes No
If yes, what medications are you taking? _____
4. Do you use tobacco? Yes No
5. Are you aware of being allergic to any medications or substance, including metals? Yes No
If yes, what? _____
6. Females Only:
 - a. Are you pregnant, or think you may be? Yes No
 - b. Are you lactating? Yes No
7. Have you ever taken bisphosphonates (Ex: Fosamax) for osteoporosis? Yes No
If yes, specify: _____
8. Please check all that apply:

Hay Fever/Allergies	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	Kidney/Liver Disease	<input type="checkbox"/>
Migraines/Frequent Headaches	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Diabetes/Low Blood Sugar	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Joint Replacement/Implant	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>
Asthma (Inhaler)	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Endocrine/Thyroid Problem	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>
Heart Trouble/Defects	<input type="checkbox"/>	Bone Disorder	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	Osteopenia/Osteoporosis	<input type="checkbox"/>
Removal of Adenoids/Tonsils	<input type="checkbox"/>	Birth defects/Hereditary problems	<input type="checkbox"/>
Bone Fractures/Major Injuries	<input type="checkbox"/>	Mental Health Problems/Depression	<input type="checkbox"/>
Arthritis/Joint Problems	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Vision/Hearing/Speech Problems	<input type="checkbox"/>	Other _____	<input type="checkbox"/>
9. Have you had allergies to the following:

<input type="checkbox"/> Local anesthetics (novacaine, lidocaine, xylocaine)	<input type="checkbox"/> Latex (gloves, balloons)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen (Motrin, Advil)
<input type="checkbox"/> Other antibiotics	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Other substances	<input type="checkbox"/> Metals (jewelry, clothing snaps)

General Information

1. What concerns you about your smile? _____
2. Who suggested that you might need orthodontic treatment? _____
3. Why did you select our office? _____
4. Have you had any previous orthodontic treatment? Please describe _____
5. Have any other family members been treated in this office? Please name them _____
6. Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain _____
7. Have you ever received cosmetic and/or therapeutic treatment using neuromodulators such as Botox, Dysport, or Xeomin and/or fillers such as Juvederm, Restylane, etc? Yes No
 - a. Would you be interested to learn more? Yes No

Dental History

Dentist _____ Phone _____ Date of last cleaning _____

1. Are you anxious or nervous about dental treatment? Yes No
2. Do you require premedication for dental treatment? Yes No
3. Have you noticed any changes in your face or jaws? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck, or jaw injuries? Yes No
If yes, please describe: _____
7. Do you have any ongoing problems in your jaw with:
 - a. Chronic clicking or popping? Yes No
 - b. Pain? Yes No
 - c. Difficulty opening or closing? Yes No
 - d. Difficulty in chewing? Yes No
8. Do you clench or grind your teeth? Yes No
9. Do you bite your lips or cheeks frequently? Yes No
10. Have you ever had speech therapy? Yes No
If yes, please describe: _____
11. Is there any outstanding dental treatment to be completed? Yes No
If yes, please describe: _____
12. Have you ever had instruction on the correct method of brushing and flossing of your teeth? Yes No
13. Do you have or have you had any of the following oral habits:
 - a. Nail biting Yes No
 - b. Thumb sucking Yes No
 - c. Tongue thrust while swallowing Yes No
 - d. Mouth breathing Yes No
14. How many times a day do you brush? _____
15. Please check the boxes below which describe the problem(s) for which you are seeking:

<input type="checkbox"/> Crowding	<input type="checkbox"/> Spacing	<input type="checkbox"/> Missing Teeth
<input type="checkbox"/> Extra Teeth	<input type="checkbox"/> Teeth stick out too far	<input type="checkbox"/> TMJ problems
<input type="checkbox"/> Teeth in the wrong position	<input type="checkbox"/> Poor bite relationship	<input type="checkbox"/> Gummy smile
<input type="checkbox"/> Decreased lip support	<input type="checkbox"/> Worn/Misshapen teeth	<input type="checkbox"/> Other
16. Have you had an orthodontic evaluation or treatment before? Yes No
If so, when and by whom? _____

Authorization and Release

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date 6/15/18

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date 6/15/18