



We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to take a few minutes to fill out this form as completely as possible.

### Patient Information - Adult

Name \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ E-mail \_\_\_\_\_  
Main Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_ Occupation \_\_\_\_\_

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### Spouse / Partner / Additional Contact Information

Name \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_ E-mail \_\_\_\_\_  
Main Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_ Relationship \_\_\_\_\_

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### Primary Dental Insurance Information

Primary Dental Plan Name \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Holder Birthday \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Group No. \_\_\_\_\_  
Member/Employee I.D. \_\_\_\_\_ Issue Date \_\_\_\_\_

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### Secondary Dental Insurance Information

Primary Dental Plan Name \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Policy Holder Birthday \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Group No. \_\_\_\_\_  
Member/Employee I.D. \_\_\_\_\_ Issue Date \_\_\_\_\_

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### Dental History

General Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Please select YES or NO for the following questions - Do not leave blank

Y N Grind or Clench Teeth	Y N Smoking/Tobacco Use	Y N Food Trapped Between Teeth
Y N Injury to Face, Jaw, Teeth or Mouth	Y N Mouth Breathing	Y N Oral Habits/Tongue Thrust
Y N Discomfort from Teeth or Gums	Y N Missing/Extra Teeth	Y N Requires Premedication
Y N Pain, Tenderness or Noise in Either Jaw	Y N Frequent Sore Throats	

If any of the above dental questions were answered 'YES', please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical History

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Please select YES or NO for the following questions - Do not leave blank

Y N Rheumatic Fever	Y N Hepatitis	Y N Seizures/Epilepsy
Y N Tuberculosis/Lung Disease	Y N Cancer/Tumor/Cyst	Y N Treated for Emotional Problems
Y N Asthma	Y N Arthritis	Y N Ever Been Hospitalized
Y N Kidney Disease	Y N Received Radiation Treatment	Y N Endocrine Problems
Y N Sleep Breathing Disorder	Y N Heart Condition	Y N Hormone Therapy
Y N Blood Disorders	Y N Nervous Disorders	Y N Autism Spectrum Disorder/ ADD/ADHD
Y N Low/High Blood Pressure	Y N Bone Disorders/Bone Loss	
Y N HIV/AIDS	Y N Diabetes	

If any of the above medical questions were answered 'YES', please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### FEMALE PATIENTS:

To the best of your knowledge, are you pregnant? Y N If yes, how long? \_\_\_\_\_

### Y N MEDICATIONS

Please list ANY medications your are currently taking

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Y N ALLERGIES

Please list ANY allergies you are aware of

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Orthodontic Consult

Yes No Have you ever had or been evaluated for orthodontic treatment? If yes, please describe

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Please list the names of any family or friends currently in the practice

\_\_\_\_\_  
\_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. It is my responsibility to inform this office of any changes in my medical status. I will not hold the doctor or staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_