

Adult Patient Information:

Date: _____

Patient's Name: _____ Male Female Prefers to be called: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ **Cell Phone Provider** (ex: Sprint, Verizon, ect.): _____ Work Phone: _____

Social Security #: _____ Birthdate: _____ Employer: _____

Please provide e-mail address (so that we may e-mail appointment dates & times to you): _____

Dentist Name: _____ **Date of Last Cleaning:** _____

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

Are other family members treated here? _____ If so, who? _____

Responsible Party/ Insurance Policy Holder Information:

*** Please complete if different from the patient's information*

Primary Responsible Party's Name: _____ Marital Status: _____

Address: _____ Cell Phone: _____

City, State, Zip: _____ **Cell Phone Provider** (ex: Sprint, Verizon, ect.): _____

Social Security#: _____ **Birthdate:** _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____

Secondary Responsible Party's Name: _____ Marital Status: _____

Address: _____ Cell Phone: _____

City, State, Zip: _____ **Cell Phone Provider** (ex: Sprint, Verizon, ect.): _____

Social Security#: _____ **Birthdate:** _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____

Dental Insurance Information:

Policy Holder's Name: _____ Insurance Company: _____

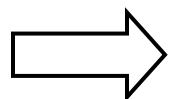
ID#: _____ Group#: _____ Insurance Co. Phone#: _____

Do you have dual coverage? Yes No ****If yes, please complete the following:**

Policy Holder's Name: _____ Insurance Company: _____

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

Please continue on the back....



Health History:

Is patient taking any medications? _____

Is patient aware of being allergic to or has ever reacted adversely to any medications? _____

Please check the box if you now have or have ever had:	Please check the box if the answer is YES :
<input type="checkbox"/> Latex Allergy <input type="checkbox"/> Tonsils or Adenoids Removed <input type="checkbox"/> Allergies/ Sinus Trouble <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> HIV Positive/ AIDS <input type="checkbox"/> TMJ Problems <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Emotional Problems/ Psychiatric Treatment	<input type="checkbox"/> Is the patient pregnant? <input type="checkbox"/> Has the patient reached puberty? <input type="checkbox"/> Thumb, finger, or lip sucking? (Please circle all that apply) <input type="checkbox"/> Mouth-breathing when awake or asleep? (Please circle all that apply) <input type="checkbox"/> Any injuries to the face, mouth, or teeth? (Please circle all that apply) <input type="checkbox"/> Any pain or popping when opening mouth? <input type="checkbox"/> Are you aware of an uncomfortable or bad bite? <input type="checkbox"/> Do you take any bisphosphate medication for osteoporosis? <input type="checkbox"/> Any missing or extra teeth?

Are you aware of any other disease, condition, or problem not listed above that we should know about? _____

Have you consulted with an orthodontist previously? _____ Reason: _____

In your own words, describe your orthodontic problem and what you would like orthodontic treatment to accomplish: _____

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs to make a thorough diagnosis of the patient's orthodontic needs and send dentist information regarding diagnostic findings. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____

