ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Nickname

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell Phone_____ Birth date_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____

Spouse's Employer_____ Occupation_____ No. years employed_____

Cell phone _____ Birth date _____ Work Phone _____

Do you have minor children? Yes / No

Child Name _____ Date of Birth ___/____/____; Child Name _____Date of Birth___/____/____

Child Name _____ Date of Birth ___/____/____; Child Name _____Date of Birth ___/____/____

Whom may we thank for referring you?_____

DENTAL INSURANCE INFORMATION

Insured's Name_____Employer_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Member ID: _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____Employer_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant? How far along? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
Address _____ Phone _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? Where? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush?
Yes No Do you have any type of thumb or tongue habit?
Yes No Are you a mouth breather?
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? Who? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day?
Yes No Have you ever been told that you grind your teeth?
Yes No Do you have “tension” headaches? How often? _____
Yes No Have you ever experienced chronic ringing in your ears?

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. Barbara Perez** to perform a complete orthodontic evaluation.

Signature: ____Date: ____________________