Adult Patient Information

Name_____Nickname_____Birthday_____ Age _____Gender___

Address _____

Home Phone_____Mobile Phone_____Other phone _____

E-mail Address _____

Employer_____ Occupation_____ Work phone _____

Spouse Name (if applicable) _____

Employer_____ Occupation_____ Work phone _____

Have any family members been seen by our office?_____If yes, who? _____

Whom may we thank for referring you?_____

Responsible Party Information

Name_____Relationship to patient _____

Mailing Address _____

Home Phone_____Mobile Phone_____Other phone _____

Dental Insurance Information

Insured's Name_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____No. years employed _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Social Security # _____ Birthdate _____ Relationship to Patient_____

Employer_____ No. years employed_____

Emergency Information

Name of preferred emergency contact _____

Address _____

Phone number_____Relationship to patient _____

Updates (date & initial)_____ _____ _____

Please complete BOTH sides of form

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 major operations? _____
Yes No Have you ever been involved in a serious accident?_____

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 Hay fever	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 other medical conditions that you feel we should be aware of?_____

_____

DENTAL HISTORY

Dentist_____ Date of last cleaning _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
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 or pressure? _____
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? _____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?_____
Yes No Has anyone in your family received orthodontic treatment? _____
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? _____
Yes No Have you ever experienced chronic ringing in your ears?_____
Yes No Are you aware that some appointments will be during work hours? _____

Female Patients only:

Yes No Are you pregnant? _____

BENEFITS AND LIMITATIONS

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 may have an atypical response 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 understand that my diagnostic records may be used for educational and training 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 Chapel Hills Orthodontics to perform a complete orthodontic evaluation.

Name:_____Signature:_____Date: _____

Updates (date & initial)_____ _____ _____ 11-06