ADULT PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of form.

Patients Name ________________________ Age______ Birthdate______________ Sex __________

Address ____

Home Phone ________________________ Cell Phone ________________________

Employer ________________________ Business Phone ________________________

Occupation ________________________ E-mail ________________________

Marital Status ________________________

Person(s) responsible for financial matters

Name(s) ________________________ Name(s) ________________________

Address ________________________ Address ________________________

City,State ________________________ City,State ________________________

Home Phone ________________________ Home Phone ________________________

Business Phone ________________________ Business Phone ________________________

Place of Employment ________________________ Place of Employment ________________________

Social Security Number ________________________ Social Security Number ________________________

Are you covered by insurance for orthodontic treatment? ❑ No ❑ Yes

If yes, by which company? ____

	Family Dentist	**Family Physician**	**Referred By**
Name	____________	____________	____________
Address	____________	____________	____________
City, State	____________	____________	____________

Your interests and hobbies ____

Reason for orthodontic consultation? ____

Has anyone in your family had a similar problem? ____

Are you self-conscious about your teeth? ____

MEDICAL HISTORY – Have you ever had any of the following? (please check off)

AIDS	Bleeding	Emotional Problems	Hepatitis	Previous Surgery
Allergy	Bone Loss / Disorders	Epilepsy / Seizures	Herpes	Rheumatic Fever
Anemia	Cold Sores	Hearing Problems	Kidney Disease	Thyroid Problems
Arthritis	Diabetes	Heart Condition	Lung Disease	Other (describe below)
Asthma	Endocrine Problems	Head or Face Injuries	Oral Ulcer	

Comments ____

____

____

Have you been under the care of a physician during the past two years, other than for routine examinations? ❑ No ❑ Yes

Condition ____

____

Date of last medical exam ________________________

Do you require antibiotic premedication for dental procedures? ❑ No ❑ Yes

Present drugs or medications ______________________________

Birth Defects ______________________________

Patient's Height ______________________________ Patient's Weight ______________________________

RESPIRATORY HISTORY

Do you:

1. Have allergies to: Drugs: ______________________________ Food: ______________________________

   Seasonal Grasses: ______________________________ Other: ______________________________

2. Breathe through mouth?	Seldom	Sometimes	Usually
3. Snore when sleeping?	No	Yes	
4. Have frequent colds?	No	Yes	
5. Have frequent "Stuffy Nose"?	No	Yes	
6. Have frequent sore throat or tonsillitis?	No	Yes	
7. Have chewing or swallowing difficulty?	No	Yes	

Have you received medical treatment from an allergist or ear, nose and throat specialist? ❑ No ❑ Yes

If yes: When ______________________________ By Whom ______________________________

Nasal Surgery ____________________ Tonsils removed ____________________ Adenoids removed ____________________

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Have you had any unusual dental experiences? ❑ No ❑ Yes

Specify ______________________________

Date of last dental checkup ______________________________ Were your teeth cleaned? ❑ No ❑ Yes

Have you had an orthodontic consult or treatment? ❑ No ❑ Yes

Do you have Headaches?_____ Neck Pain?_____ Jaw Pain?_____ Ear Pain?_____ Face Pain?_____ Eye Pain?_____ Other?_____

Which side hurts? Right______ Left______ Both______

How long have you had these symptoms? ______ years ______ days ______ months

Is the pain constant?______ aching?_____ shooting?_____ burning?_____ stabbing?_____ electrical?_____ other?_____

Worse in the afternoon?_____ Worse in the morning?_____ Does it hurt to chew?_____ Does it hurt to open wide?_____

Does your jaw make a popping noise?______ clicking?_____ grinding?_____ other?_____

Has your jaw ever "locked" or slipped out of place? ______________________________

Do you ever clench or grind your teeth?______ During the day?_____ During the night?_____

Do you have problems with your ears?______ Hearing?_____ Dizziness?_____ other?_____

Is it difficult to swallow? ______________________________ Painful? ______________________________

Are your teeth sore or sensitive? ______________________________

Additional comments ______________________________

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Signature ______________________________ Date ______________________________