



Adult History

Today's Date: _____

Name: _____
Last First MI MR MRS MS DR

I prefer to be called: _____ Male Female Birthdate ___/___/___ Age: _____

Home address: _____

City _____ State _____ Zip _____

Home#: _____ Cell#: _____ E-Mail: _____

Single Married Divorced Widowed Separated

Employer: _____ Work# _____

Occupation: _____

Orthodontic Insurance

Name of Insurance Co.: _____ Phone #: _____

Address: _____

Subscriber I.D.#: _____ Group #: _____

Subscriber Name: _____ SS# _____ DOB: _____

Employer Name: _____

Secondary Insurance: _____ Phone#: _____

Address: _____

Subscriber I.D.#: _____ Group #: _____

Subscriber Name: _____ SS# _____ DOB: _____

Employer Name: _____

Dental & Medical History

General Dentist _____ Date of Last Cleaning: _____

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

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

Have you ever had orthodontic treatment before? Yes No

Have you ever had any injuries to the face, mouth, teeth, or chin? Yes No

Please describe: _____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Do you require pre-medication prior to dental visits? Yes No

Your current dental health is: Good Fair Poor

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Please list medications you are currently taking: _____

Please list any medications/foods that you are allergic to: _____

Have you ever been diagnosed with any of the following diseases/medical problems? (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Headaches/pain of face & head | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Pressure (high/low) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Clenching/Grinding teeth |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mouthbreather |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Liver Problems | <input type="checkbox"/> Tongue Thrust |

Other? Please describe: _____

If female, are you pregnant? Yes No Week #: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____