

Adult New patient Form

First name _____ Last name _____ Male or female
home phone # (____) _____ Cell # (____) _____ birthdate _____ age _____
home address _____ City _____ Zip _____

who referred you? " _____ "

Employed by _____ phone # (____) _____ Occupation _____

Marital Status: Single Married Widowed Separated Divorced

Spouse's Name: _____ Occupation _____

Business address _____ Employer _____ Phone (____) _____

ORTHODONTIC INSURANCE INFORMATION: Do you have insurance? yes no not sure

Primary Orthodontic Insurance _____ Group# _____

Name of Subscriber: _____ Date of Birth _____

Social Security number _____

Secondary Orthodontic Insurance: _____ Group# _____

Name of Subscriber: _____ Date of birth _____

Social Security number _____

Patient's Dentist: _____ City _____ last visit _____

Health History - check any that apply: _____ Comments

Any injury or operation to face, mouth or teeth? Please List; _____

Do you have any speech difficulty? _____

Do you grind or clench your teeth during the day or night? _____

Do you have difficulty chewing? _____

Pain or noise from jaw joint? _____ Inability to open wide or move jaw normally? _____

Prior orthodontic work or consultation with an Orthodontist? _____

Do you have any bridges or crowns? _____

Concerned about the appearance of your teeth _____

primary reason for seeking an Orthodontist? _____

Do you know of any missing or extra teeth? _____

Are your teeth difficult to clean? _____

Please check any that apply:

___ rheumatic fever _____ emotional problems

___ nervous disorders _____ endocrine disorders

___ lung disease _____ cancer /tumors

___ high blood pressure _____ anemia

___ ulcers _____ epilepsy

___ asthma or hay fever _____ sinus problems

___ liver trouble / hepatitis _____ immune deficiency or HIV

___ arthritis _____ venereal disease

___ speech problems _____ radiation treatment

___ headaches _____ bone disorder

___ ear problems _____ heart disease or murmur

___ Tonsils or Adenoids removed?

Any Medical problems not listed?

please explain; _____

Patient's Physician _____ City _____ last visit _____

Currently under treatment for: _____

Medication now being taken _____

List any drug sensitivity or allergies _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Signature _____ SS# _____ Date _____