NEW PATIENT FORM (ADULT)

How did you hear about us? _____

What is the most important thing you would like for us to fix? _____

Appointment Reminder Preference: ❑ Text ❑ Phone Call ❑ Email (Email Address:)_____

Patient Name (First, Middle Initial, Last): _____

Birth Date: _____ Age: _____ **Sex: Male ❑ Female ❑**

S.S.N.: _____ **Home Phone No.: _____**

Patient's Address: _____

City: _____ **State: _____ Zip/Postal Code: _____**

Occupation: _____ **Employer: _____Years with emplyer: _____**

Business Phone No: _____

Name of Spouse/Closest Relative: _____ **Relationship to you: _____**

Spouse/Relative Contact #: _____

Dentist Name: _____ **Phone: _____**

Address: _____

Physician's name: _____ **Phone: _____**

Address: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security#: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Date of Birth: _____

Social Security#: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City _____State _____ Zip _____

Insurance Company: _____

Group #: _____

Address: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: _____

MEDICAL HISTORY: Now or in the past, have you had:

❑ Yes	❑ No	Birth defects or hereditary problems?
❑ Yes	❑ No	Bone fractures, any major accidents?
❑ Yes	❑ No	Rheumatoid or arthritic conditions?
❑ Yes	❑ No	Endocrine or thyroid problems?
❑ Yes	❑ No	Kidney problems?
❑ Yes	❑ No	Diabetes?
❑ Yes	❑ No	Cancer, tumor, radiation treatment or chemotherapy?
❑ Yes	❑ No	Stomach ulcer or hyperacidity?
❑ Yes	❑ No	Polio, mononucleosis, tuberculosis or pneumonia?
❑ Yes	❑ No	Problems of the immune system?
❑ Yes	❑ No	AIDS or HIV positive?
❑ Yes	❑ No	Hepatitis, jaundice or liver problems?
❑ Yes	❑ No	Fainting spells, seizures, epilepsy or neurological problem?
❑ Yes	❑ No	Mental health disturbance of behavioral problem?
❑ Yes	❑ No	Vision, hearing, tasting or speech difficulties?
❑ Yes	❑ No	Loss of weight recently, poor appetite?
❑ Yes	❑ No	History of eating disorder (anorexia, bulimia)?
❑ Yes	❑ No	Bleeding disorder, bruising tendency, excessive bleeding or anemia?
❑ Yes	❑ No	High or low blood pressure?
❑ Yes	❑ No	Tires easily?
❑ Yes	❑ No	Chest pain, shortness of breath or swelling ankles?
❑ Yes	❑ No	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn hear defects, hear murmur or rheumatic heart disease)?
❑ Yes	❑ No	Skin disorder?
❑ Yes	❑ No	Do you eat a well-balanced diet?
❑ Yes	❑ No	Frequent headaches, colds or sore throats?
❑ Yes	❑ No	Eye, ear, nose or throat condition?
❑ Yes	❑ No	Hayfever, asthma, sinus trouble or hives.
❑ Yes	❑ No	Tonsil or adenoid conditions?
❑ Yes	❑ No	Osteporosis?

WOMEN ONLY

❑ Yes	❑ No	Are you pregnant?
❑ Yes	❑ No	Are you anticipating becoming pregnant?

Allergies or reactions to any of the following:

❑ Yes	❑ No	Local anesthetics (Novocaine or Lidocaine)?
❑ Yes	❑ No	Aspirin?
❑ Yes	❑ No	Ibuprofen (Motrin, Advil)?
❑ Yes	❑ No	Penicillin or other antibiotics?
❑ Yes	❑ No	Sulfa drugs?
❑ Yes	❑ No	Codeine or narcotics?
❑ Yes	❑ No	Metals (jewelry, clothing snaps)?
❑ Yes	❑ No	Latex (gloves, balloons)?
❑ Yes	❑ No	Vinyl?
❑ Yes	❑ No	Acrylic?
❑ Yes	❑ No	Animals?
❑ Yes	❑ No	Foods (specify)? _____
❑ Yes	❑ No	Other substances (specify)? _____
		_____

❑ Yes	❑ No	Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

❑ Yes	❑ No	Do you currently have or ever had a substance abuse problem?
❑ Yes	❑ No	Do you chew or smoke tobacco?
❑ Yes	❑ No	Operations? (specify) _____
❑ Yes	❑ No	Hospitalized? (for) _____
❑ Yes	❑ No	Other physical problem or symptoms? (describe) _____
❑ Yes	❑ No	Being treated by another health care professional? (for) _____
		Date of most recent physical exam: _____
❑ Yes	❑ No	Are there any other medical conditions that we should be aware of?
		_____

I have read and understand the above questions. I will not hold my orthodontist or any staff member responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date signed: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)

DENTAL HISTORY: Now or in the past, have you had:

❑ Yes	❑ No	Would you object to wear orthodontic appliances (braces) should they be indicated?
❑ Yes	❑ No	Concerns about your profile?
❑ Yes	❑ No	Concerns about spaced, crooked or protruding teeth?
❑ Yes	❑ No	Aware or concerned about under or over developed jaw?
❑ Yes	❑ No	Any relative with similar tooth or jaw relationships?
❑ Yes	❑ No	Have teeth grown-in quickly or slowly?
❑ Yes	❑ No	Thumb, finger or sucking habit? Until what age? _____
❑ Yes	❑ No	Abnormal swallowing or tongue thrust habit?
❑ Yes	❑ No	History of speech problems?
❑ Yes	❑ No	Mouth breathing, snoring or difficulty in breathing?
❑ Yes	❑ No	Had periodontal (gum) treatment?

❑ Yes	❑ No	Permanent or "extra" (supernumerary) teeth removed?
❑ Yes	❑ No	Chipped teeth or other wise injured teeth?
❑ Yes	❑ No	Teeth sensitive to hot or cold; throb or ache?
❑ Yes	❑ No	Jaw fractures, cysts or mouth infections?
❑ Yes	❑ No	"Dead teeth" or root canals treated?
❑ Yes	❑ No	Food impactions between teeth?
❑ Yes	❑ No	Tooth grinding, jaw clenching, clicking or locking?
❑ Yes	❑ No	Any pain in jaw or ringing in the ears?
❑ Yes	❑ No	Any pain or soreness in the muscles of the face or around the ears?
❑ Yes	❑ No	Difficulty in chewing or jaw opening?
❑ Yes	❑ No	Any loose, broken or missing fillings?
❑ Yes	❑ No	"Gum Boils" canker sores, or cold sores?
❑ Yes	❑ No	Taking any forms of fluoride?
❑ Yes	❑ No	Any serious trouble associated with any previous dental treatment?

❑ Yes ❑ No **Have you ever had an orthodontic examination or received orthodontic treatment before?**

Doctor's name: _____ Date of Exam/Treatment: _____

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Signed: _____ Date signed: _____
(Patient)

Signed: _____ Date signed: _____
(Dental Staff Member)