

ADULT INFORMATION FORM

Patient's Name _____ Date of Birth _____ Age _____

Address _____

Phone _____ Email _____

Occupation _____ Employer _____

Spouse's Name _____ Employer _____

Who is the Responsible Party? _____

Referred By _____ Have You Seen Another Orthodontist? _____

Patient's Dentist _____ Physician _____

DENTAL INSURANCE

Primary Insurance _____ Policy Holder Name _____ DOB _____ SSN _____

Secondary Insurance _____ Policy Holder Name _____ DOB _____ SSN _____

MEDICAL HISTORY

Significant medical conditions _____

Current medications and reason _____

Allergies _____

Have the following been removed? Tonsils _____ Adenoids _____ Wisdom Teeth _____

Do you have a heart murmur or synthetic joint that requires you to take antibiotics before dental work? _____

DENTAL HISTORY

What concerns you about your teeth? _____

Other family members with similar orthodontic problems _____

Any injuries to face, mouth, or teeth? _____ Any missing or extra permanent teeth? _____

Have you ever been treated for periodontal (gum) disease? _____ Any active dental decay? _____

Does the patient have speech problems? _____

Is the patient a mouth breather? _____ Finger sucking habit? _____ Until what age? _____

Does the patient have a history of TMJ (jaw) clicking, popping, or pain? _____

Signature _____ Date _____

OFFICE USE ONLY: Estimated Fee _____ Treatment Length _____