PATIENT INFORMATION
ADULT

Date _____

Personal Information

Name_____
Last First MI

Address_____
Street Apt#

_____
City State Zip

Birthdate_____ Age_____

SSN_____-_____-_____ ☐ Male ☐ Female

Home Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Employer_____

Occupation_____ How Long_____

Work Phone (_____)_____-_____ ext_____

Whom may we thank for referring you to our office?

_____

General Dentist's Name_____

Phone (_____)_____-_____

Date of Last Visit_____

Emergency Contact Information

Name_____
Last First MI

Address_____
Street Apt#

_____
City State Zip

Home Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Relationship_____

Insurance Information

Do you have orthodontic coverage ☐ Yes ☐ No

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Phone (_____)_____-_____

Group/Plan#_____

Name of Primary Insured_____

Relationship to Patient_____

Primary's Employer_____

Primary's Birthdate_____

Primary's SSN _____-_____-_____

Authorization

This office reserves the right to verify the credit status of potential patients and/or responsible parties prior to extending credit for treatment fees and may, at its discretion, use the services of one or more credit reporting services.

Insurance is billed as a courtesy. I understand that I am responsible for payment of services rendered, including any co-payments and deductibles that my insurance does not cover.

I hereby authorize the office to release all information necessary to secure the payment of benefits. I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

PLEASE COMPLETE THE INFORMATION ON THE BACK

PATIENT HEALTH QUESTIONNAIRE

Dental Information

Main Concerns

	Mild	Moderate	Severe
Facial Pain	☐	☐	☐
Gum Problems	☐	☐	☐
Jaw Dysfunction	☐	☐	☐
Neck Pain	☐	☐	☐
Bad Bite	☐	☐	☐
Crowded Teeth	☐	☐	☐
Impacted Tooth/Teeth	☐	☐	☐
Missing Tooth/Teeth	☐	☐	☐
Protrusion of Teeth	☐	☐	☐
Spaces	☐	☐	☐
Underbite	☐	☐	☐
Dentist Recommended	☐	☐	☐

Other_____

Have you ever had:

Yes	No		Yes	No	
☐	☐	Chin Injury	☐	☐	Mouth Injury
☐	☐	Clicking in the Jaw Joint	☐	☐	Pain in Jaw Joint
☐	☐	Difficulty Chewing	☐	☐	Smoking
☐	☐	Difficulty Swallowing	☐	☐	Snoring
☐	☐	Finger Sucking	☐	☐	Sore Teeth
☐	☐	Grinding Teeth	☐	☐	Speech Problems
☐	☐	Gums Bleeding/Sore	☐	☐	Tooth/Teeth Injury
☐	☐	Headaches	☐	☐	Thumb Sucking
☐	☐	Lip Biting	☐	☐	Tongue Thrusting
☐	☐	Mouth Breathing	☐	☐	Tonsillitis

☐ Other_____

How often do you have regular dental checkups?
☐ Twice a year
☐ Once a year
☐ Only if necessary
☐ Never

How do you feel about orthodontic treatment?
☐ Eager for treatment
☐ Willing if necessary
☐ Dreading but agree
☐ Unwilling

Orthodontic consultation was prompted by:
☐ Patient
☐ Dentist
☐ Other_____

Have you ever had a previous orthodontic consultation or treatment?
☐ Yes ☐ No
Name of the Dr._____

Have you ever had any unusual dental experiences?
☐ Yes ☐ No

Medical Information

Have you ever had or do you currently have any of the following:

Yes	No		Yes	No	
☐	☐	Allergies	☐	☐	Endocrine Problems
☐	☐	Arteriosclerosis	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Female Problems
☐	☐	Autoimmune Disorder	☐	☐	Hearing Disorders
☐	☐	Blood Disease	☐	☐	Heart Disease
☐	☐	High Blood Pressure	☐	☐	Hepatitis
☐	☐	Low Blood Pressure	☐	☐	HIV/AIDS/ARC (please circle)
☐	☐	Bone Disorders	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Ringing of Ears
☐	☐	Dizziness	☐	☐	Sleep Disturbance
☐	☐	Emotional Problems	☐	☐	Trauma (to face, teeth, jaw, or head)

Have you ever been told to pre-medicate before dental procedures?
☐ Yes ☐ No

☐ Other_____

Are you currently taking any medications?
☐ Yes ☐ No
If so please list them:_____

_____

Are you allergic to any of the following:
☐ Antibiotics (specify) _____
☐ Dairy Products
☐ Food Dyes
☐ Pain Pills (specify) _____
☐ Wheat Products
☐ Latex
☐ Metals_____
☐ Other_____

For Women:
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

How would you rate your overall health?
☐ Good ☐ Fair ☐ Poor

Are there any other medical, dental, surgical, or psychological problems not covered?
☐ Yes ☐ No
If so please list them:_____

_____

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

_____
Signature Date