GET IT STRAIGHT

ORTHODONTICS

Adult Patient Information

Today's Date _____

Patient's Name _____ **I prefer to be called** _____

Address _____ **City** _____

Zip_____

Email Address_____ **Home Phone** _____

Work Phone _____ **Cell Phone** _____ **Best way to contact** _____

SSN _____ **DOB** ____/____/____ **Age** _____ **Sex** _____

Employer _____**Occupation**_____ **How Long?** _____

Spouse _____**Work Phone**_____ **Cell Phone** _____

Employer _____**Occupation**_____ **How Long?** _____

General Dentist _____ **City**_____**Last Visit** _____

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

Marital Status_____ **Person Responsible for this account** _____

If different then above:

BillingAddress _____ **City** _____ **Zip** _____

Email Address _____ **Home Phone** _____ **Cell Phone** _____

SSN _____ **DOB** ____/____/____ **Age**_____ **Sex** _____

Orthodontic Insurance Information

Primary Dental Insurance **Orthodontic Coverage** ☐ Yes ❑ No

Insured's Name _____ **Relation:** _____ **Employer:** _____

DOB ____/____/____ **SSN** _____

Insurance Company _____ **Group No.** _____ **Insurance IDN** _____

Insurance Company Address _____ **City** _____ **Zip** _____

Insurance Company Phone _____

Do you have dual coverage? ❑ Yes ☐ No

Secondary Dental Insurance **Orthodontic Coverage** ☐ Yes ❑ No

Insured's Name _____ **Relation** _____ **Employer** _____

DOB ____/____/____ **SSN** _____

Insurance Company _____ **Group No.** _____ **Insurance IDN** _____

Insurance Company Address _____ **City** _____ **Zip** _____

Insurance Company Phone _____

Emergency Information

Contact Person _____ **Relation** _____ **Phone** _____

Medical History

Physician's Name_____ Last Visit _____ Phone Number _____

Current physical condition ❑ Good ❑ Fair ❑ Poor Are you currently under the care of a physician? ❑ Yes ❑ No

Have you ever been under the care of a physician for a major illness? ❑ Yes ❑ No _____

Please answer all questions by checking 'Yes' or 'No".

Good Health	❑ Yes ❑ No	Bleeding disorder	❑ Yes ❑ No
Recent illness	❑ Yes ❑ No	Prolonged bleeding	❑ Yes ❑ No
Recent cold, cough	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No
Heart or chest pain	❑ Yes ❑ No	Sickle cell anemia	❑ Yes ❑ No
Heart murmur	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	Joint replacement	❑ Yes ❑ No
Rheumatic fever	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Kidney disease	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Lung disease	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Hay fever, seasonal allergies	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	Nasal obstruction	❑ Yes ❑ No
Herpes (cold sores)	❑ Yes ❑ No	Severe headaches	❑ Yes ❑ No
AIDS or HIV positive	❑ Yes ❑ No	Bone disorder	❑ Yes ❑ No
Endocrine disorder	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Growth disorder	❑ Yes ❑ No	Canker Sores	❑ Yes ❑ No
Tonsils/Adenoids removed	❑ Yes ❑ No	Antibiotics required for Dental appointments	❑ Yes ❑ No

List any drugs (prescription and over the counter) that you are currently taking and please give reason _____

List any allergies or sensitivities Including drug, latex metal or other _____

Are you taking any medication for osteoporosis? If so, what and for how long? _____

Are you now, or could you be pregnant? ❑ Yes ❑ No If yes, how many weeks? _____

Dental History

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

Current Dental Health ❑ Good ❑ Fair ❑ Poor Do you like your smile? ❑ Yes ❑ No

Have you ever been treated with orthodontics before? ❑ Yes ❑ No If yes, please explain: _____

Do you have any history of gum or periodontal disease? ❑ Yes ❑ No

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

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Have you ever had injuries to your face, mouth, teeth or chin? ❑ Yes ❑ No

Do you generally breath through your mouth? Awake: ❑ Yes ❑ No Asleep ❑ Yes ❑ No

Do you have any missing or extra permanent teeth? ❑ Yes ❑ No If yes, please explain: _____

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

Signature_____ **Date** _____