

## PATIENT INFORMATION FORM FOR ADULTS

Full Name \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

General Dentist Name and Address \_\_\_\_\_

Referred By \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Place Of Employment \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

SS# \_\_\_\_\_

Place of Employment \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_

If you have moved within the last two years, list previous address.

\_\_\_\_\_

In case of emergency, please list nearest relative \_\_\_\_\_

### DENTAL INSURANCE INFORMATION AND AUTHORIZATION:

Name and Address of Ins. Co. \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ I.D. No. \_\_\_\_\_

#### Authorization:

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH QUESTIONNAIRE**

**DATE** \_\_\_\_\_

**NAME** \_\_\_\_\_

**1. Do you have regular Dental-Medical exams? Yes No**  
**Last Dental Appt. and Procedures?** \_\_\_\_\_  
**Date of last x-rays?** \_\_\_\_\_

**2. Has there been any change in your general health within the past year?** \_\_\_\_\_

**3. Are you under the care of a physician currently and if so for what condition?** \_\_\_\_\_

**4. Name and address of treating physician :** \_\_\_\_\_  
\_\_\_\_\_

**5. Have you been hospitalized or had any serious illness and if so for what condition, illness or operation?** \_\_\_\_\_

**6. Do you have or had any of the following?**  
**A. Rheumatic Fever or Rheumatic Heart Disease? Yes No**  
**B. Scarlet Fever? Yes No**  
**C. Congenital Heart Lesions? Yes No**  
**D. Mitral Valve Prolapse? Yes No**  
**E. Allergies to Drugs, Anesthetics, or Other? Please Specify**

\_\_\_\_\_  
**F. Sinus problems, Hay Fever? Yes No**  
**G. Asthma? Yes No**  
**H. Epilepsy, Cerebral or Spastic Condition? Yes No**  
**I. Blood Disorder (Anemia, Hemophilia)? Yes No**  
**J. Herpes? Yes No**  
**K. Hepatitis? Yes No**  
**L. Tuberculosis? Yes No**  
**M. HIV/AIDS? Yes No**

**7. Have you come in contact with someone with Hepatitis, Tuberculosis, or HIV/AIDS? If yes, please specify.** \_\_\_\_\_

**8. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No**  
**A. Have you ever required a blood transfusion? If so, explain** \_\_\_\_\_

**9. Have you had surgery or x-ray treatment for a tumor, growth or condition of the mouth, lips? Yes No**

**10. Are you employed in any situation which they are exposed regularly to x-rays? Yes No**

**11. Do you smoke? Yes No**

**12 . Women: Are you pregnant? Yes No**

DENTAL QUESTIONNAIRE

DATE \_\_\_\_\_

NAME \_\_\_\_\_

1. Please state your reason for this orthodontic visit. \_\_\_\_\_

\_\_\_\_\_

2. Have you ever experienced any of the following:

- |  |     |    |
|--|-----|----|
| A. Trouble associated with previous dental treatment | Yes | No |
| B. Dental discomfort at this time                    | Yes | No |
| C. Current gum bleeding                              | Yes | No |
| D. Tooth sensitivity to cold, hot, sweets or chewing | Yes | No |
| E. Jaw clicking                                      | Yes | No |
| F. Pain in or around the ears                        | Yes | No |
| G. Frequent sores in and around the mouth            | Yes | No |
| H. Fear of dentistry                                 | Yes | No |
| I. Had periodontal (gum) treatment                   | Yes | No |
| J. Had orthodontic treatment before                  | Yes | No |
| K. Biting habits                                     | Yes | No |
| L. Thumb or finger sucking habits                    | Yes | No |

3. Do you breathe through your mouth primarily? Yes No

4. Do you grind or clench your teeth? Yes No

5. Have you ever been told that you have a tongue thrust or reverse swallowing pattern? Yes No

6. Have you had your tonsils and or adenoids removed. Yes No  
If yes, please indicate which. \_\_\_\_\_

7. Is there any hereditary background which may contribute to this orthodontic problem? Please specify. \_\_\_\_\_

*Please notify the office of any change in health or dental status !!*

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received a copy of this offices's Notice of Privacy Practices.

\_\_\_\_\_  
(Please print patient's name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\*\*Please note that the office "Notice of Privacy Practices" is also posted in the office lobby**