ADULT FORM

PATIENT INFORMATION FORM

NO. _____

Welcome to our office . . .
Please assist us by completing the following questions:

DATE OF EXAM ..... 20.....
DATE OF BIRTH .....

PATIENT'S NAME..... AGE..... SEX .....
Last First Initial

ADDRESS ..... CITY ..... POSTAL CODE ..... PHONE .....

MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ REMARRIED ☐ WIDOW ☐

PATIENT'S DENTIST..... PHYSICIAN .....

REFERRED BY.....

NAMES OF OTHER MEMBERS OF YOUR FAMILY TREATED BY OUR OFFICE.....

PERSON RESPONSIBLE FOR ACCOUNT.....

ADDRESS..... CITY..... POSTAL CODE .....

DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? YES ☐ NO ☐

PATIENT'S EMPLOYED BY.....

PATIENT'S OCCUPATION ..... BUS. TELEPHONE.....

SPOUSE'S NAME ..... BUS. TELEPHONE.....

MEDICAL HISTORY

Check any of the following the patient has had:

Diabetes ☐	Arthritis ☐	Gland Problems ☐
Pneumonia ☐	Anemia ☐	Prolonged Bleeding ☐
Heart Trouble ☐	Epilepsy ☐	Liver Involvement ☐
Rheumatic Fever ☐	Asthma ☐	Fainting & Dizziness ☐
Bone Disorder ☐	Kidney Involvement ☐	Nervous Disorder ☐

	Yes	No	?
ARE YOU IN GOOD HEALTH?	☐	☐	☐
ARE YOU UNDER A PHYSICIAN'S OR CHIROPRACTOR'S CARE NOW?	☐	☐	☐
DO YOU HAVE A HISTORY OF MAJOR ILLNESS OR OPERATIONS? GIVE DETAILS?	☐	☐	☐
WOMEN: ARE YOU PREGNANT?	☐	☐	☐
DO YOU HAVE A SERIOUS DISEASE THAT CAN BE SPREAD BY MOUTH CONTACT? (e.g., HEPATITIS, HERPES)	☐	☐	☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS.....

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LIST ANY ALLERGIES OR DRUG SENSITIVITY.....

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE?	☐	☐	☐

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? If so, describe	☐	☐	☐
DO YOU HAVE ANY PROBLEMS WITH YOUR SPEECH?	☐	☐	☐
DO YOU BREATHE PREDOMINATELY THROUGH YOUR MOUTH?	☐	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐	☐
HAVE YOU HAD ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS?	☐	☐	☐
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?	☐	☐	☐
HAVE YOU HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS?	☐	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐	☐
HAVE YOU HAD ANY PERIODONTAL TREATMENT?	☐	☐	☐
DO YOU FEEL THAT YOU NEED ORTHODONTIC TREATMENT?	☐	☐	☐
ARE YOU APPREHENSIVE ABOUT ORTHODONTIC TREATMENT?	☐	☐	☐
WHEN DID YOU LAST VISIT YOUR DENTIST? IS THERE ANY DENTAL WORK STILL TO BE DONE?	☐	☐	☐
WOULD YOU MIND WEARING BRACES?	☐	☐	☐

LIST SPORTS, HOBBIES AND INTERESTS.....

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REASON FOR ORTHODONTIC EXAMINATIONS .....

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Recall..... Patient's Signature .....