ADULT PATIENT INFORMATION

(Please write in information and bring to your appointment)

Account #_______________

Date____________________

Patient's name ____
Last First Middle Nickname

Street Address ____
Street City Zip

Mailing Address ____
Street City Zip

Home phone (___) _________________ Cell phone (___) _______________ Work phone (___) ______________________

Patient's Dentist____________________ Patient's Birth date ______________ Age___________ □ Male □ Female

Patient's Social Security Number___________________ Email Address____

Patient's Employer______________________________ Occupation ____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Separated Spouse's Name__________________________

Spouse's Employer________________________________ Spouse's Work phone (___) ___________________________

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

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Insured's Name__________________________________ Insured's Social Security #_______________________________

Insurance Company ____________________________ Insured's birth date __________Insured's Employer__________

Insurance Co. Address ____
Box or Street City Zip

Insurance Group No. ______________________________ Insurance Co. Phone No. ______________________________

Insured's relationship to patient ______________________________ Do you have dual coverage? Yes____ No_____

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete address____
Street City Zip

Relationship of nearest relative_________________________ Home Phone (___) ________ Cell Phone (___) _________

ADULT PATIENT INFORMATION
MEDICAL HISTORY

Physician ____Date of Last Visit ____________________________

Address ____Phone (___) _________________________________

Circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____

Yes No Are you allergic to any medication? ____

Yes No Do you have a history of a major illness? ____

Yes No Have you had any operations? ____

Yes No Have you ever been involved in a serious accident? ____

Yes No Have you ever smoked or chewed tobacco? ____

Yes No Have you seen a physician in the last 12 months? Why? _______________________________________

Yes No Are you pregnant?____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
ADD/ADHD	Dizziness	Herpes/Venereal disease	Prolonged Bleeding/Anemia
Arthritis	Epilepsy	High or Low Blood Pressure	Radiation/Chemotherapy
Asthma/Hay fever/Sinus problems	Gastrointestinal Disorders	HIV/Aids/Blood Transfusions	Rheumatic Fever
Bone Disorders	Heart Problems/stroke	Kidney problems	Sickle cell
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tuberculosis
			Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ___________________________
____

Circle any allergic reactions to the following:

Yes	No	Aspirin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/metals	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

DENTAL HISTORY

General Dentist ____ Date of last visit _________________________________
What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain? ____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____________________________________
Yes No Have your wisdom teeth been removed? ____
Yes No Have you ever lost or chipped any teeth? ____
Yes No Have there been any injuries to face, mouth, or teeth? ____
Yes No Is any part of your mouth sensitive to temperature? Where? ____
Yes No Is any part of your mouth sensitive to pressure? Where? ____
Yes No Do your gums bleed when you brush? ____
Yes No Do you have any type of thumb or tongue habit? ____
Yes No Are you a mouth breather? ____
Yes No Have you ever seen an orthodontist? If yes, who and when? ____
Yes No What is your attitude toward receiving orthodontic treatment? ____
Yes No Has anyone in your family received orthodontic treatment? ____
How did they feel about the result? ____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ________________________
Yes No Are you aware of your jaw clicking or popping? ____
Yes No Are you aware of clenching your teeth during the day? ____
Yes No Have you ever been told that you grind your teeth? ____
Yes No Do you have “tension” headaches? ____
Yes No Have you ever experienced chronic ringing in your ears? ____
Yes No Are you aware that appointments will be during work hours? _________________________________

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph.
I also understand that my diagnostic records and my name may be used for educational and promotional purposes.
I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Lee Engel to perform a complete orthodontic evaluation.

Signature:____ Date:_____________

____

-FOR OFFICE USE ONLY-

Recall
1Yr _________
6 Mo ________
3 Mo ________

Teeth to be Extracted
____
____

Case Fee____________