Adult Form
18+

W E L C O M E

TO THE SMILE DR.

"We Make Our Patients' Smile"

About You

Today's Date: _____

Name: _____
Last First MI MR MRS MS DR

I prefer to be called: _____

Birth __/__/__ Age: _____ ☐ Male ☐ Female

E-mail Address: _____

SS #: _____ DL #: _____

Home #: ( ) _____ Cell Phone #: ( ) _____

Work #: ( ) _____ Ext.: _____ Other #: ( ) _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____

Orthodontic Insurance

Do you have orthodontic coverage? ☐ Yes ☐ No

Primary Insurance

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group # / ID #: _____

Insured's Name: _____ Relation: _____

Insured's Birth date: __/__/__ Insured's SS#: _____

Insured's Employer: _____

Secondary Insurance

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group # / ID #: _____

Insured's Name: _____

Insured's Birth date: __/__/__ Insured's SS#: _____

Insured's Employer: _____

Who is responsible for account? _____

Spouse Information

His/ Her Name: _____

Employer: _____

Wk #: ( ) _____ Ext: _____ SS #: _____

Birth __/__/__

Whom should we contact in case of emergency?

Name: _____

Relation: _____ Phone #: ( ) _____

Address: _____

_____

Email: _____ This Email belongs to: _____

For online access to appointments, financials, treatment photos & x-rays, and much more!

Orthodontics & Dental

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

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Was it in our office? (Please specify) _____

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

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: Mouth Teeth Chin (Please circle & explain) _____

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Do you have any speech problems? _____

Continued on Back

Dental & Medical History

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No

Have you ever had any pain/ tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you brush your teeth daily? ☐ Yes ☐ No

Floss teeth daily? ☐ Yes ☐ No

Physician: _____

Phone #: _____ Date of last visit: _____

For women: Are you taking birth control pills? ☐ Yes ☐ No
Has menstruation begun? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking medication for Osteoporosis? ☐ Yes ☐ No

Please describe your physical health: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Are you taking any prescription/ over-the-counter drugs? ☐ Yes ☐ No

Please list: _____

Please list any serious medical condition(s) that you have ever had:

Aside from items below, list all drugs/ materials that you are allergic to:

☐ Y ☐ N Latex ☐ Y ☐ N Nickel/ Metals ☐ Y ☐ N Plastic

Have you ever had any of the following medical problems?

☐Y ☐N	Abnormal Bleeding	☐Y ☐N	Hemophilia
☐Y ☐N	Anemia	☐Y ☐N	Hepatitis
☐Y ☐N	Artificial bones/ Joints/ Valves	☐Y ☐N	High/Low Blood Pressure
☐Y ☐N	Asthma/ Arthritis	☐Y ☐N	HIV+/AIDS
☐Y ☐N	Blood Transfusion	☐Y ☐N	Hospitalized for any reason
☐Y ☐N	Cancer / Chemotherapy	☐Y ☐N	Kidney Problems
☐Y ☐N	Congenital Heart Defect	☐Y ☐N	Osteoporosis
☐Y ☐N	Diabetes	☐Y ☐N	Mitral Valve Prolapsed
☐Y ☐N	Difficulty Breathing	☐Y ☐N	Psychiatric Problems
☐Y ☐N	Drug / Alcohol Abuse	☐Y ☐N	Depression
☐Y ☐N	Eating Disorder	☐Y ☐N	Radiation Treatment
☐Y ☐N	Emphysema	☐Y ☐N	Rheumatic/Scarlet Fever
☐Y ☐N	Epilepsy/Seizures/Fainting	☐Y ☐N	Severe/Frequent Headaches
☐Y ☐N	Fever Blisters/Herpes	☐Y ☐N	Shingles
☐Y ☐N	Glaucoma	☐Y ☐N	Sickle Cell Disease/ Traits
☐Y ☐N	Heart Attack/Stroke	☐Y ☐N	Sinus Problems
☐Y ☐N	Heart Murmur	☐Y ☐N	Ulcers/Colitis
☐Y ☐N	Headaches	☐Y ☐N	Venereal Disease
☐Y ☐N	Heart Surgery/Pacemaker		

Have you ever taken any diet pills such as Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If so, when? _____
Have you ever taken any bisphosphonates (include all generic and trade names): ☐ Yes ☐ No If so, medical reason for treatment? _____

Have you ever been diagnosed with tuberculosis? ☐ Yes ☐ No
Have you had a persistent cough greater than 3 weeks? ☐ Yes ☐ No
Have you had a cough that produces blood? ☐ Yes ☐ No

Authorization

This office reserves the right to verify the credit status of potential patients and/ or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And 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.
I understand that the information I have given is correct to the best of my knowledge, that is will be held at the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental/ orthodontic services needed.

_____
Signature of Patient Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/ dental information above with the patient named herein. _____
Signature of Dentist Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your health status since your last visit? ☐ Yes ☐ No

Dentist Signature: _____ Date: _____ Patient Signature: _____ Date: _____