Please complete both portions of this form

Diplomates, American Board of Orthodontics

Adult Patient Information

Date: ______________________

Last Name: ________________________ First Name: ______________________ Preferred Name: ________________

Address: ____________________________ City: __________________________ State: ______ Zip: _____________

Home Phone: _________________ Cell Phone: ________________ Preferred Contact Phone: _________________

Birthdate: ________________________________ Age: ______________________ Sex: ☐ M ☐ F

Dentist: ______________________________________ Physician: ____

Has any member of your family been a patient of this office before? ☐ Yes ☐ No
Name(s): ____

Who may we thank for recommending our office to you? ____

Employed By: ____ Business Phone: ________________________

Business Address: ____

E-mail Address: ____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Responsible Party (If other than patient)

Person Responsible for account: ____

Relationship to Patient: _______________________________ Social Security Number: ________________________

Home Address: ____

City: ____ State: _________ Zip: __________________

Home Phone: _________________ Cell Phone: ________________ Preferred Contact Phone: _________________

Employed By: ____ Business Phone: ________________________

Business Address: ____

Orthodontic Insurance: ☐ Yes ☐ No (if “Yes”, fill out form provided)

(OVER)

Medical History

Please check any of the following for which the patient has been treated:

- ☐ Diabetes
- ☐ Pneumonia
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Auto-Immune Disease
- ☐ Vision/Eye Problems
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Asthma
- ☐ Anemia
- ☐ Prolonged Bleeding
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Arthritis
- ☐ Hearing Problems
- ☐ Bone Disorders
- ☐ Endocrine/Hormonal Problems
- ☐ Heart Murmur
- ☐ Kidney Involvement
- ☐ Nervous Disorders
- ☐ Thyroid Problems
- ☐ Fainting or Dizziness
- ☐ Cold Sores/Fever Blisters
- ☐ Adenoids/Tonsils Removed
- ☐ Stomach/Digestive Disorders

List any other serious illnesses or medical problems ______________________________

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

If yes, please specify conditions ______________________________

List **ALL** Allergies (including those to any drugs, medications, or **METALS**) ______________________________

List any drugs/medications now taken ______________________________

Do you require antibiotics before dental appointments? ☐ Yes ☐ No`

Do you take any calcium supplements (ex: Fosamax, etc) for osteoporosis? ☐ Yes ☐ No

Dental History

	Yes	No
Date of last dental appointment: ____________ Were X-rays taken?	☐	☐
Have you been informed of any missing or impacted teeth?	☐	☐
Have your wisdom teeth been extracted?	☐	☐
Do your gums bleed upon brushing or flossing?	☐	☐
Are you currently seeing a periodontist?	☐	☐
If so, whom? ______________________________		
Have there been any injuries to the face, mouth or teeth?	☐	☐
Do you have pain, popping or clicking upon opening and closing the mouth?	☐	☐
Have you ever had splint therapy or worn a night guard?	☐	☐
Prescribed by whom? ______________________________		
Have you had any previous orthodontic consultation or treatment?	☐	☐
With whom? ______________________________		

What would you like to have orthodontic treatment accomplish? ______________________________

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A credit history may be obtained in order to make financial arrangements.

______________________________ ____________

Patient Signature Date