ORTHODONTIC ADULT PATIENT INFORMATION

Welcome to our office:

The following information is requested to enable me to give you the best consideration of your orthodontic problem during the initial examination. For me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records, is confidential. Thank You.

Patient's Name _____ Age_____ Date of Birth _____/_____/____ Sex_____
LAST FIRST MIDDLE

Home Address _____ How Long? _____
STREET CITY ZIP

Employer: _____ # Yrs. Employed? ____ Occupation _____ Work Phone_____

Home Phone _____ Cell. Phone _____ Social Security #: _____ Marital Status: _____

Physician _____ Dentist_____

Whom may we thank for referring you to our practice?_____

Husband/Wife _____ Work #:_____ Cell #:_____

Employer: _____ Yrs. Employed?_____ Social Security #: _____

Occupation: _____ Person(s) Responsible for Account_____

Email Address:_____

Emergency Information

Name of Nearest Relative Not Living With You?_____ Relation to Pt.: _____

Address: _____ Telephone: _____

Medical History (Please Check Those That Apply)

❒ Arthritis	❒ Blood Disease	❒ Heart Disease	❒ Mononucleosis	❒ Thyroid Problems
❒ Anemia	❒ Diabetes	❒ Hepatitis	❒ Nasal / Sinus Problems	❒ Tuberculosis
❒ Asthma	❒ Epilepsy	❒ HIV Positive	❒ Rheumatic Fever	❒ Other: (describe below)
❒ Back/Neck Pain	❒ Hearing Disorder	❒ Kidney Disease	❒ Speech Disorder	

Comments:_____

Is antibiotic medication necessary before dental appointments due to a heart condition? ..... ❒ Yes ❒ No

Have you been under the care of a physician during the past two years, other than for routine examinations? ..... ❒ Yes ❒ No

Why? _____

Present drugs or medications:_____

Do you use any kind of tobacco? ..... ❒ Yes ❒ No If yes, How much? _____ per day, week or month

Do you have any emotional or psychological disturbances? If yes, briefly describe: _____

_____

Female patients: Are you pregnant or could you possibly be pregnant?..... ❒ Yes ❒ No

Respiratory History

1. Do you have allergies to: Seasonal grasses ❒ Yes ❒ No Foods ❒ Yes ❒ No Metals ❒ Yes ❒ No Latex ❒ Yes ❒ No

Drugs ❒ Yes ❒ No Other:_____

If Yes, please specify: _____

2. Breathe through mouth regularly?..... ❒ Usually ❒ Sometimes ❒ Seldom

3. Snore when sleeping?..... ❒ Yes ❒ No

4. Have you received medical treatment from an allergist or ear, nose, and throat specialist? ..... ❒ Yes ❒ No

If Yes, When? _____ By Whom? _____

For What?_____

5. Do you have chewing or swallowing difficulty? ..... ❒ Yes ❒ No

(Complete Reverse Side)

Dental History

Do you visit your dentist regularly (twice a year)? ☐ Yes ☐ No

When was your last visit to your dentist? _____ Were your teeth cleaned? ☐ Yes ☐ No

How many times do you brush your teeth daily? 1☐ 2☐ 3☐ More ☐ Floss Daily? ☐ Yes ☐ No

Facial or dental injury due to accidents or blows to the mouth? ☐ Yes ☐ No

If Yes, Explain: _____

_____

Have you been informed of congenitally missing, extra, or impacted teeth? ☐ Yes ☐ No

Have you had any teeth extracted due to decay or gum disease? ☐ Yes ☐ No

Have you ever been treated by a periodontist (Gum Specialist)? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you have headaches frequently? ☐ Yes ☐ No

How often? _____ In the morning? ☐ Yes ☐ No In the evenings? ☐ Yes ☐ No

Other: _____

Location of headaches? _____

Have you ever experienced pain, clicking, or popping in your jaw joints? ☐ Yes ☐ No

Pain R☐ L☐ Clicking R☐ L☐ Popping R☐ L☐ Earaches R☐ L☐

Has your jaw ever locked open? ☐ Yes ☐ No Locked Closed? ☐ Yes ☐ No

Have you ever been treated for temporomandibular joint (TMJ) problems? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

Has an orthodontist been consulted previously? ☐ Yes ☐ No

Have you had orthodontic treatment previously? ☐ Yes ☐ No

By whom? _____ When? _____

Were you pleased with the results? ☐ Yes ☐ No

Has anyone in your family had orthodontic treatment? ☐ Yes ☐ No

Has there been any apprehension or unfavorable experience in a dental office? ☐ Yes ☐ No

Do you gag or faint easily? ☐ Yes ☐ No

What is the primary reason you are seeking this orthodontic evaluation?

_____

_____

_____

What concerns do you have about braces, orthodontic treatment, etc.?

_____

_____

_____

Please Read, Sign and Date: I, the undersigned, verify the accuracy of the above information. If there are any changes in the future, I will inform this practice of these changes. I hereby authorize Dr. Stephen E. Searcy to obtain any information that may be required for credit acceptance in connection with the financial arrangements for orthodontic treatment.

Signature of Patient/Responsible Party	Date	Signature of Witness	Position (TC, etc.)

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