

ADULT PATIENT INFORMATION

Date \_\_\_\_\_
Patient's name \_\_\_\_\_ Last First Middle
Residence \_\_\_\_\_ Street City Zip
Mailing Address \_\_\_\_\_ Street City Zip
Home phone \_\_\_\_\_ Cell/other Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_
Email Address \_\_\_\_\_ Marital Status: Single\_\_ Married\_\_ Widowed\_\_ Separated\_\_ Divorced\_\_
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_
Spouse's Name \_\_\_\_\_
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_
Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Work Phone \_\_\_\_\_
Whom may we thank for referring you to our office? \_\_\_\_\_

DENTAL INSURANCE INFORMATION

Insured Name \_\_\_\_\_ Insured Social Security # \_\_\_\_\_
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_
Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_
Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:
Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_
Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_
Complete address \_\_\_\_\_ Street City Zip
Home phone \_\_\_\_\_ Cell/other Phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Responsible Party Signature \_\_\_\_\_
Updates (date & initial) \_\_\_\_\_

## MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please 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, metals, plastic or latex? \_\_\_\_\_  
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 seen a physician in the last 12 months? Why? \_\_\_\_\_

### Female Patients only:

Yes No Are you pregnant? \_\_\_\_\_  
Yes No Do you take Bisphosphonate medications for osteoporosis or cancer? \_\_\_\_\_

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

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous/Psychiatric Disorders	Tumor or Cancer

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

## DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Did your dentist refer you to our office? YES or NO (circle response)

What concerns you most about your teeth or smile? \_\_\_\_\_

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 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? \_\_\_\_\_  
What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

## 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. I understand that the information that I have given here is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical and/or dental status. I authorize the dental/orthodontic staff to perform any necessary dental/orthodontic services and procedures that I may need during diagnosis and treatment, with my informed consent. 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 the office, use the services of one or more credit reporting services. I have read and understand this paragraph. In addition, I authorize Dr. Tsibel to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_