ADULT PATIENT INFORMATION

Date____________________

Patient's name____
Last First Middle
Mailing Address____
Street City Zip
How long at this address? ________ Birthdate____________________ Social Security # ______________________
Cell Phone_______________________ Home phone______________________ Work phone ________________________

Email Address_____________________ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___
Employer__________________________________ Occupation_____________________ No. years employed__________
Spouse's Name____ Relationship to Patient ___________________
Employer__________________________________ Occupation_____________________ No. years employed__________
Social Security #_______________________________ Birthdate ____________________Work Phone_______________
Whom may we thank for referring you to our office? ____

DENTAL INSURANCE INFORMATION

Insured's Name____ Insured's Social Security #___________________
Insurance Company__________________________ Group No._________________ Local No._____________________
Insurance Co. Address____ Phone No.____________________

SECONDARY INSURANCE INFORMATION

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: ______________________________ Phone # ____________________

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

Parent 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? ____
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 seen a physician in the last 12 months? Why? ______________________________________
Female Patients only:
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
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions/special needs we have not discussed that you feel we should be aware of? __________
____

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 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 Are you aware that some appointments will be during work hours?

AUTHORIZATION

I attest that I have answered all the above questions truthfully and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Tsibel to perform a complete orthodontic evaluation.

Signature: ________________________________ Date: ____________________