ADULT PATIENT INFORMATION

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address?_____

Previous address (if less than 3 years)_____

Cell phone_____ **Email address**_____

Home phone_____Work phone_____

Social Security #_____**Date of Birth**_____

Employer_____Occupation_____# years employed____

Gender(circle) Male / Female

Marital status: Single___ Married___ Widowed____ Separated___ Divorced___

Spouse's Name_____

Employer_____Occupation_____# years employed____

Social Security #_____Date of Birth_____

Cell phone_____Work phone_____

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

DENTAL INSURANCE INFORMATION

Insured's Name_____Insured's Social Security#_____

Insurance Company_____**Insured's Date of Birth**_____

Subscriber# / ID#_____Group#_____

Insurance Co. claims mailing address_____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____Insured's Social Security#_____

Insurance Company_____**Insured's Date of Birth**_____

Subscriber# / ID#_____Group#_____

Insurance Co. claims mailing address_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Address_____

Phone_____

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 chew ed tobacco?_____
Yes No Have you seen a physician in the last 12 months? Why?_____

Female patients only:

Yes No Are you pregnant?_____
Yes No Has menstruation started?_____

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 disorders	Tumor of Cancer

Are there any medical conditions w e have not discussed that you feel w e should be aw are of?_____
_____

DENTAL HISTORY

General Dentist_____ Date of last visit_____
Address_____ Phone_____
What concerns you most about your teeth?_____

Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced and unfavorable reaction to dentistry?_____
Yes No Have your w isdom teeth been removed?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to the 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 w hen 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, w ho and w hen?_____
Yes No Has anyone in your family received orthodontic treatment?_____
How did they feel about the result?_____
Yes No Do your teeth or jaw s ever feel uncomfortable w hen you aw ake in the morning?_____
Yes No Are you aw are of your jaw clicking or popping?_____
Yes No Are you aw are 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 Have you ever experienced chronic ringing in your ears?_____
Yes No Are you aw are that some appointments w ill be during w ork hours?_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of teeth, in the general function of teeth, and in general dental health. Teeth, gums, and jaw s are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answ ered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Niaraki, Dr. Fadiani, Dr. Baquerizo, and Dr. Hostage to perform a complete orthodontic evaluation.

Signature:_____ Date:_____