Adult New Patient Form

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant, stress free and educational. We pride ourselves in creating beautiful smiles that lasts a lifetime. We look forward to seeing you in the office.

First Name *

Last Name *

Title

I prefer to be called

Month of Birth *

Day of Birth *

Year of Birth *

Social Security Number

Email address

General Dentist

Date of Last Appointment

Who may we thank for referring you to our office?

Other Family Members Seen by Us

Home Address

Street Address

Address Line 2

City

State

Zip Code

Home Phone #

Cell Phone #

Work Phone #

Employer Information

Employer Name

How Long There?

Occupation

Spouse Information

Name

Month of Birth

Day of Birth

Year of Birth

Work Phone #

Cell Phone

Home Phone

Billing Address

Employer Name

Person Responsible for Account

Name

Work Phone #

Cell Phone

Home Phone

Primary Orthodontic Insurance

Orthodontic Coverage

Yes No

Policy Holder's Name

Month of Birth

Day of Birth

Year of Birth

Social Security Number

Employer Name

Insurance Company

Insurance Company Address

City/state/zip

Insurance Company Phone #

Group / Plan #

Relationship to Patient

Social Security Number

Medical History

Do you have a personal physician?

Yes No

Physician Name

Date of Last Visit

Please describe your physical health

Excellent Good Fair Poor

Please list all medications that you are currently taking and for what conditions

Please list any medications that you are currently allergic to.

For Women

Are you pregnant?

Yes No

If yes how many weeks?

What are the main concerns you would like orthodontics to address?

Patient's concerns

Dentist's concerns

Has you ever had or been evaluated for orthodontic treatment before?

Have there been any injuries to the face, teeth, jaw, mouth or chin? Please explain

Have adenoids or tonsils been removed?

Yes No

Have you been informed of any missing or extra permanent teeth?

Yes No

If yes, which ones?

Have you ever had any pain or tenderness in the jaw joint (TMJ, TMD)?

Yes No

Do you brush your teeth daily?

Yes No

Do you floss your teeth daily?

Yes No

Have you ever had any of the following medical issues? (Please fill each one of these out in order to continue and submit this form).

Abnormal Bleeding *

Yes No

Allergies to any drugs *

Yes No

Allergy to latex/metals *

Yes No

Allergy to plastic *

Yes No

Any Hospital Stays *

Yes No

Any Operations? *

Yes No

Asthma *

Yes No

Cancer *

Yes No

Congenital Heart Defect *

Yes No

Convulsions/Epilepsy *

Yes No

Diabetes *

Yes No

Handicaps/Disabilities *

Yes No

Hearing Impairment *

Yes No

Heart Murmur *

Yes No

Hemophilia *

Yes No

Hepatitis *

Yes No

HIV + /AIDS *

Yes No

Kidney / Liver Problems *

Yes No

Rheumatic / Scarlet Fever *

Yes No

Tuberculosis (TB) *

Yes No

Please list an emergency contact not living with you

Name

Phone

Address

City, State, Zip

Agree To Terms

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status. I also authorize the dental staff to perform the necessary orthodontic services as needed. I further authorize that photos taken during treatment may be used in journal articles or promotional materials and are the property of our office. I understand that where appropriate, credit bureau reports may be obtained.

Yes

I Agree to the above terms and conditions *