ADULT

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Member American Association of Orthodontists

Patient Information

Name: _____ E-mail:_____

SS #_____ Driver's License # _____ Birthdate_____ Age_____

Home Phone: _____ Cell Phone: _____ Male [ ] Female [ ]

Home Address:_____

City:_____ State: _____ Zip: _____

Employer: _____ How long there?_____

Occupation: _____ Work Phone: _____

Where and when is the best time to reach you?_____

Family Dentist: _____ Last Visit: _____ Physician: _____

Children (names and ages) _____

Has any member of your family been a patient in our office? Yes [ ] No [ ]

Names: _____

Whom may we thank for telling you about us? (dentist, friends, family members)_____

_____

Marital Status: Married [ ] Divorced [ ] Widowed [ ] Single [ ] Separated [ ]

Spouse information:

Name: _____ SS# _____

Employer: _____ Work Phone:_____

Emergency Contact:_____

Are you covered by orthodontic insurance? Yes [ ] No [ ] If yes, please bring card with you.

Name of insurance _____

What are the main concerns that you would like orthodontics to accomplish? _____

_____

_____

Health History

Have you been out of the country in the last six months? Yes [ ] No [ ]

Have you:

ever been evaluated or had orthodontic treatment before Yes [ ] No [ ]

If yes, by whom? _____

ever had any injuries to the face, mouth, teeth, chin Yes [ ] No [ ]

had adenoids or tonsils removed Yes [ ] No [ ]

ever been informed of any missing/extra teeth Yes [ ] No [ ]

ever had any pain/tenderness/clicking in the jaw joint Yes [ ] No [ ]

ever used a c-pap (sleep apnea) Yes [ ] No [ ]

Do/did you have any of the following habits:

clenching/grinding teeth (at night) Yes [ ] No [ ]

mouth breather Yes [ ] No [ ]

nail biting Yes [ ] No [ ]

speech problems Yes [ ] No [ ]

tongue thrust Yes [ ] No [ ]

thumb, finger, lip sucking or biting Yes [ ] No [ ]

smoker (cigarette or electronic) Yes [ ] No [ ]

Are you in good health? Yes [ ] No [ ]

Have you had any history of:

anemia Yes [ ] No [ ]

blood transfusion Yes [ ] No [ ]

hemophilia, hepatitis, HIV+/AIDS Yes [ ] No [ ]

congenital heart defect or heart murmur Yes [ ] No [ ]

artificial valves Yes [ ] No [ ]

heart attack/stroke Yes [ ] No [ ]

heart surgery/pacemaker Yes [ ] No [ ]

Have you had any history of:

high/low blood pressure Yes [ ] No [ ]

diabetes Yes [ ] No [ ]

kidney or liver problems Yes [ ] No [ ]

asthma, allergies or hay fever Yes [ ] No [ ]

emphysema Yes [ ] No [ ]

tuberculosis (TB) Yes [ ] No [ ]

sinus problems Yes [ ] No [ ]

severe/frequent headaches Yes [ ] No [ ]

rheumatic or scarlet fever Yes [ ] No [ ]

fever blisters/herpes/shingles Yes [ ] No [ ]

cancer Yes [ ] No [ ]

chemotherapy Yes [ ] No [ ]

psychiatric problems Yes [ ] No [ ]

hearing impairment, handicaps, or disabilities Yes [ ] No [ ]

hospital stays or operations Yes [ ] No [ ]

artificial bones/joints Yes [ ] No [ ]

convulsions, epilepsy, or seizures Yes [ ] No [ ]

ulcers/colitis Yes [ ] No [ ]

allergies to latex, plastic or any metals Yes [ ] No [ ]

Women:

Are you taking birth control pills? Yes [ ] No [ ]

Are you pregnant? (wks_____) Yes [ ] No [ ]

Are you nursing? Yes [ ] No [ ]

Are you post-menopausal? Yes [ ] No [ ]

History of Fosamax use? Yes [ ] No [ ]

Please discuss any medical problems that you have/had: _____

_____

Please list all medications you are currently taking: _____

_____

Please list all medications you are allergic to: _____

_____

I understand 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 that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform the necessary dental services I may need. I acknowledge that I have received a copy of the Notice of Privacy Practices of the office of Joseph R. Gregg DDS, MSD. I authorize the release of rights to photographs and orthodontic records for the use by Joseph R. Gregg DDS, MSD.

*Signature:*_____ *Date:*_____

update:

_____	_____	_____
_____	_____	_____
_____	_____	_____

For Office Use Only

_____	_____	_____
Name	*Initial*	*Date*

I verbally reviewed the health information above with the patient named herein.

Name:_____ **Date:**_____