nirenblatt
ORTHODONTICS

ADULT PATIENT INFORMATION

Date

Patient's Name
Last First Middle

Mailing Address
Street City Zip

How long at this address? Home phone Work phone

Cell Phone Birthdate Social Security #

Email Address Marital Status: Single Married Widowed Separated Divorced

Are you employed? Yes or No Employer's name or source of income No. years employed

Spouse's name Relationship to patient

Is spouse employed? Yes or No Employer's name or source of income No. years employed

Social Security # Birthdate Work Phone

How have you heard of our office? Please check all that apply ◯ Friend Friend's Name:

◯ Internet ◯ Your Dentist ◯ Family Member ◯ Facebook ◯ Direct Mail ◯ Drive By Sign

◯ Television ◯ Previous Patient ◯ Insurance Plan ◯ Radio ◯ Staff Member ◯ School

DENTAL INSURANCE INFORMATION

Insured's Name Birthdate Insured's Social Security #

Insurance Company Group# ID#

Insurance Co. Address Phone No.

Do you have dual coverage? Yes No If yes:

Insured's Name Birthdate Insured's Social Security #

Insurance Company Group# ID#

Insurance Co. Address Phone No.

EMERGENCY INFORMATION

Name of nearest relative not living with you

Complete address

Phone

AGREEMENT

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature of Parent/Patient/Guardian

Date

FOR OFFICE USE ONLY

Date: Date:

Reviewed by: Reviewed by:

Doctor's notes: Doctor's notes:

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ADULT PATIENT MEDICAL HISTORY INFORMATION

Name of Physician: When was your last visit?

Address Phone

List all medications you are taking:

List any allergies you may have:

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 you seen a physician in the last 12 months? Why?

Yes No Female patients only: Are you pregnant?

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

Abnormal bleeding/hemophilia	Bone Disorders	Heart Problems	Psychological Condition
Addiction	Congenital Heart Defect	Hepititis/Liver problems	Radiation/Chemotherapy
Anemia	Diabetes	Herpes	Rheumatic Fever
Anxiety	Diziness	High Blood Pressure	Tuberculosis
Arthritis	Epilepsy	HIV / AIDS	Tumor or Cancer
Artificial Joints	Gastrointestinal Disorders	Kidney Problems	
Asthma or Hayfever	Heart Murmur	Neurological Condition	

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

DENTAL HISTORY

General Dentist **When was your last cleaning?**

Yes No Are you presently in 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? Do you snore heavily?

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 Does your jaw click or pop?

Yes No Do you grind or clench your teeth?

Yes No Do you have difficulty opening your mouth?

Yes No Do you have frequent headaches?

What would you like to change about your smile?