



**Adult Patient Information**

Today's Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Best way to contact \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Spouse \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
General Dentist \_\_\_\_\_ City \_\_\_\_\_ Last Visit \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
Marital Status \_\_\_\_\_ Person Responsible for this account \_\_\_\_\_  
If different then above:  
Billing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**Orthodontic Insurance Information**

*Primary Dental Insurance* Orthodontic Coverage ? Yes  No  
Insured's Name \_\_\_\_\_ Relation: \_\_\_\_\_ Employer: \_\_\_\_\_  
DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Insurance IDN \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_  
Do you have dual coverage?  Yes ? No  
*Secondary Dental Insurance* Orthodontic Coverage ? Yes  No  
Insured's Name \_\_\_\_\_ Relation \_\_\_\_\_ Employer \_\_\_\_\_  
DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Insurance IDN \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Phone \_\_\_\_\_

**Emergency Information**

Contact Person \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Last Visit \_\_\_\_\_ Phone Number \_\_\_\_\_

Current physical condition  Good  Fair ? Poor Are you currently under the care of a physician?  Yes  No

Have you ever been under the care of a physician for a major illness?  Yes  No \_\_\_\_\_

**Please answer all questions by checking 'Yes' or 'No'.**

Good Health  Yes  No

Recent illness  Yes  No

Recent cold, cough  Yes  No

Heart or chest pain  Yes  No

Heart murmur  Yes  No

High blood pressure  Yes  No

Rheumatic fever  Yes  No

Kidney disease  Yes  No

Lung disease  Yes  No

Diabetes  Yes  No

Hepatitis  Yes  No

Herpes (cold sores)  Yes  No

AIDS or HIV positive  Yes  No

Endocrine disorder  Yes  No

Growth disorder  Yes  No

Tonsils/Adenoids removed  Yes  No

Bleeding disorder  Yes  No

Prolonged bleeding  Yes  No

Leukemia  Yes  No

Sickle cell anemia  Yes  No

Anemia  Yes  No

Joint replacement  Yes  No

Arthritis  Yes  No

Asthma  Yes  No

Sinus problems  Yes  No

Hay fever, seasonal allergies  Yes  No

Nasal obstruction  Yes  No

Severe headaches  Yes  No

Bone disorder  Yes  No

Epilepsy  Yes  No

Canker Sores  Yes  No

Antibiotics required for

Dental appointments  Yes  No

List any drugs (prescription and over the counter) \_\_\_\_\_  
that you are currently taking and please give reason \_\_\_\_\_  
\_\_\_\_\_

List any allergies or sensitivities \_\_\_\_\_  
Including drug, latex metal or other \_\_\_\_\_  
\_\_\_\_\_

Are you taking any medication for osteoporosis? If so, what and for how long? \_\_\_\_\_

Are you now, or could you be pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

## Dental History

What are the main concerns you would like \_\_\_\_\_  
orthodontics to accomplish? \_\_\_\_\_

Current Dental Health  Good  Fair  Poor Do you like your smile?  Yes  No

Have you ever been treated with orthodontics before?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have any history of gum or periodontal disease?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?  Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Have you ever had injuries to your face, mouth, teeth or chin?  Yes  No

Do you generally breath through your mouth? Awake:  Yes  No Asleep  Yes  No

Do you have any missing or extra permanent teeth?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

I have read and understand the above questions. I will not hold Dr. Newman or and member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_