A B C

ADULT PATIENT INFORMATION

Date:___________________

Patient's name: ____
Last First Middle

Residence: ____
Street City Postal Code

Mailing Address: ____
Street City Postal Code

Home phone:_________________________ Work phone:__________________________________

Cell Phone:______________________ Birth date: _______________ Age:______ Sex: **F** or **M**

Email Address:____

Occupation:________________________ Business Address:_____________________Bus.Tel:_______________

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

Do you carry orthodontic insurance? **YES** or **NO** If yes (InsuranceCarrier):______________________________

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 chewed tobacco?________________________________
Yes No Have you seen a physician in the last 12 months? Why?________________________________
Female Patients only:
Yes No Are you pregnant?________________________________

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 Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

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

DENTAL HISTORY

General Dentist ____Date of last visit____________________________
What concerns you most about your teeth? ________________________________

Yes No Are you presently in any 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? ________________________________
Yes No Have you ever seen an orthodontist? If yes, who and when?________________________________

Yes No Has anyone in your family received orthodontic treatment? ________________________________
How did they feel about the result?________________________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?________________________________
Yes No Are you aware of your jaw clicking or popping? ________________________________
Yes No Are you aware 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?________________________________

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws 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 answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr.Douglas to perform a complete orthodontic evaluation.

Signature: ________________________________Date: ____________________