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ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Mailing Address if different _____

How long at this address? _____ Home phone_____ Cell phone _____ Work phone _____

Previous address (if less than 3 years)

_____

Email address_____ other family members in practice_____

Birthdate_____ Marital Status: Single___ Married___ Widowed___ Separated___ Divorced__ Partnership___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to patient _____

Employer_____ Occupation_____ No. years employed _____

Birthdate_____ Cell Phone _____ Work Phone _____

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

ORTHODONTIC INSURANCE INFORMATION

Insured's Name_____ Relationship to patient _____ Insured's Social Security # _____ Insured's birthdate _____ Insurance

Company_____ Group No._____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insured's birthdate _____ Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained. If you are ready for treatment, we will obtain a report today. If you do not wish to have a report obtained, please do not sign below.

Patient Signature _____

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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 medications, please list _____
Yes No Are you allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Have you had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have you seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Are you pregnant or think you might be? _____

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

Abnormal bleeding/Hemophilia	Diabetes	High Blood Pressure
ADHD/ADD	Dizziness	HIV / Aids
Anemia	Epilepsy	Kidney Problems
Anxiety/nervousness	Gag reflex	Pneumonia
Arthritis	Gastrointestinal Disorders	Prolonged Bleeding
Asthma or Hay fever	Heart Problems	Radiation/Chemotherapy
Autism	Heart Murmur	Rheumatic Fever
Bone Disorders	Hepatitis/Liver problems	Tuberculosis
Congenital Heart Defect	Herpes	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 Ever experienced any unfavorable reaction to dentistry? _____
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 gums bleed when brushing? _____
Yes No 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 What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience “tension” headaches? _____
Yes No Have you experienced chronic ringing in the ears? _____
Yes No Do you need extra help with instructions? _____
Yes No Are you sensitive or self-conscious about your teeth? _____
Yes No Are you aware that some appointments will be during work hours? _____

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 also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Pezoldt to perform a complete orthodontic evaluation.

Signature: _____ Date: _____