ADULT PATIENT INFORMATION FORM

EXAM DATE ____/____/____ (MM / DD / YYY)

PATIENT NAME ____ (LAST / FIRST / INITIAL) ☐Mr. ☐Miss ☐Ms. ☐Mrs. ☐Dr. DATE OF BIRTH ____/____/____ (MM / DD / YYY)

ADDRESS ____ CITY ____ POSTAL CODE ____

PHONE NUMBER ____ E-MAIL ____ AGE ____ SEX ____

PATIENT'S OCCUPATION ____ EMPLOYED BY ____

ARE YOU FINANCIALLY RESPONSIBLE FOR YOUR OWN ACCOUNT? ☐ YES ☐ NO

DO YOU HAVE INSURANCE? ☐ YES ☐ NO IF YES, FILL OUT ATTACHED FORM.

IF YOU ANSWERED NO TO THE ABOVE TWO QUESTIONS, PERSON(S) RESPONSIBLE FOR ACCOUNT:

NAME ____ NAME ____

ADDRESS: ____ ADDRESS: ____

PHONE NUMBER: ____ PHONE NUMBER: ____

RELATIONSHIP TO YOU ____ RELATIONSHIP TO YOU ____

DO THEY HAVE INSURANCE? ☐ YES ☐ NO IF YES, FILL OUT ATTACHED FORM.

PATIENT'S DENTIST ____ PHYSICIAN ____

WHOM MAY WE THANK FOR REFERRING YOU? ☐ DENTIST ☐ PHONEBOOK ☐ FRIEND ☐ RELATIVE ☐ INTERNET ☐ OTHER ____

LIST ANY FAMILY MEMBERS THAT ARE PATIENTS IN OUR OFFICE ____

WHAT IS YOUR CHIEF CONCERN? WHAT BROUGHT YOU HERE? PLEASE BE SPECIFIC

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD:

YES	NO		YES	NO		YES	NO	
☐	☐	ALZHEIMER'S DISEASE	☐	☐	EXCESSIVE THIRST	☐	☐	PERSISTENT COUGHING
☐	☐	ANAPHYLAXIS	☐	☐	FAINTING SPELLS/DIZZINESS	☐	☐	PNEUMONIA
☐	☐	ANEMIA	☐	☐	FREQUENT DIARRHEA	☐	☐	PROLONGED BLEEDING
☐	☐	ANGINA	☐	☐	GLAND PROBLEMS	☐	☐	PSYCHIATRIC CARE
☐	☐	ARTHRITIS	☐	☐	GLAUCOMA	☐	☐	RADIATION TREATMENTS
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HAY FEVER	☐	☐	RECENT WEIGHT LOSS
☐	☐	ARTIFICIAL JOINT	☐	☐	HEART ATTACK/FAILURE	☐	☐	RENAL DIALYSIS
☐	☐	ASTHMA	☐	☐	HEART DISEASE	☐	☐	RHEUMATIC FEVER
☐	☐	BLOOD DISEASE	☐	☐	HEART MURMUR	☐	☐	RHEUMATISM
☐	☐	BLOOD TRANSFUSION	☐	☐	HEART PACE MAKER	☐	☐	SCARLET FEVER
☐	☐	BONE DISORDER	☐	☐	HEMOPHILIA	☐	☐	SHINGLES
☐	☐	BRUISE EASILY	☐	☐	HEPATITIS	☐	☐	SICKLE CELL DISEASE
☐	☐	CANCER	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SINUS TROUBLE
☐	☐	CHEMOTHERAPY	☐	☐	HIVES OR RASH	☐	☐	SPINA BIFIDA
☐	☐	CHEST PAINS	☐	☐	HYPOGLYCEMIA	☐	☐	STOMACH DISORDER
☐	☐	CONVULSIONS	☐	☐	IMMUNE DEFICIENCY (HIV/AIDS)	☐	☐	STROKE
☐	☐	CORTISONE MEDICINE	☐	☐	IRREGULAR HEARTBEAT	☐	☐	SWELLING OF LIMBS
☐	☐	DO YOU SMOKE OR USE SMOKLESS TOBACCO?	☐	☐	KIDNEY DISEASE	☐	☐	THYROID DISEASE
☐	☐	DIABETES	☐	☐	LEUKEMIA	☐	☐	TONSILLITIS
☐	☐	DRUG ABUSE	☐	☐	LIVER DISEASE	☐	☐	TUBERCULOSIS
☐	☐	EASILY WINDED	☐	☐	LUNG DISEASE	☐	☐	TUMORS OR GROWTHS
☐	☐	EMOTIONAL DISORDER	☐	☐	LOW BLOOD PRESSURE	☐	☐	ULCERS
☐	☐	EMPHYSEMA	☐	☐	MITRAL VALVE PROLAPSE	☐	☐	VENEREAL DISEASE
☐	☐	EPILEPSY	☐	☐	PARATHYROID DISEASE	☐	☐	YELLOW JAUNDICE

YES NO

☐ ☐ DO YOU HAVE OR HAVE YOU EVER HAD ANY DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED ABOVE? SPECIFY:

____

WHAT IS YOUR PRESENT HEALTH? ☐ GOOD ☐ FAIR ☐ POOR

☐ ☐ ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR DRUGS? SPECIFY:

____

TURN OVER

YES NO

☐ ☐ DO YOU HAVE ANY ALLERGIES OR DRUG SENSITIVITY? SPECIFY: _____

☐ ☐ IS YOUR PHYSICIAN CURRENTLY TREATING YOU FOR ANY CONDITIONS?

☐ ☐ DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS? SPECIFY: _____

☐ ☐ HAVE YOU HAD TONSILS OR ADENOIDS REMOVED? AT WHAT AGE?_____

LIST SPORTS, HOBBIES AND INTERESTS _____

DENTAL HISTORY

HAVE YOU HAD PREVIOUS ORTHODONTIC CARE OR CONSULTATION? ☐ YES ☐ NO

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

YES NO

☐ ☐ ANY INJURIES TO THE: ☐ FACE ☐ MOUTH ☐ TEETH

☐ ☐ TOOTHACHE

☐ ☐ TEETH SENSITIVE TO ☐ HOT ☐ COLD

☐ ☐ GUM DISEASE

☐ ☐ LUMPS OR SORES IN MOUTH

☐ ☐ HERPES/APTHOUS ULCERS

☐ ☐ SPEECH PROBLEMS?

☐ ☐ HAVE YOU EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? _____

☐ ☐ ARE YOU A MOUTH BREATHER? ☐ WHILE AWAKE ☐ WHILE A SLEEP

☐ ☐ ARE YOU AWARE OF ANY : ☐ MISSING TEETH ☐ EXTRA PERMANENT TEETH

HAVE YOU EVER HAD ANY PROBLEMS OR SIDE EFFECTS ASSOCIATED WITH PREVIOUS DENTAL CARE? ☐ YES ☐ NO

WHEN DID YOU LAST HAVE DENTAL EXAM AND CLEANING? _____

ARE THERE ANY FILLINGS/CROWNS STILL TO BE DONE? ☐ YES ☐ NO IS THE APPOINTMENT SCHEDULED? ☐ YES ☐ NO

IF YES, DATE: _____

TMJ

YES NO

☐ ☐ DO YOU CLENCH OR GRIND YOUR TEETH?

☐ ☐ DO YOU EVER HEAR: ☐ CLICKING ☐ GRINDING SOUNDS IN YOUR JAW JOINT? ☐ LEFT ☐ RIGHT

☐ ☐ HAVE YOUR JAWS EVER LOCKED: ☐ OPEN? ☐ CLOSED?

☐ ☐ DO YOU GET FREQUENT: ☐ HEADACHES? ☐ SORE FACIAL MUSCLES?

☐ ☐ DO YOU WANT ORTHODONTIC TREATMENT IF INDICATED?

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

OFFICE USE ONLY

TC NOTES _____

CLINICAL OBSERVATIONS _____

ESTIMATED: COST _____

TIME _____

PROVISIONAL TREATMENT PLAN _____