Patient Information

All About You

Name:_____

I prefer to be called:_____

☐ Male ☐Female DOB:___/____/____ Age:_____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

SS#:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home #: ( ) _____ Email:_____

Occupation: _____

Employer:_____ How long?:_____

Work #:( )_____

Work Address:_____

City:_____ State:_____ Zip:_____

Who can we thank for referring you?:_____

Other Contact Information

His/Her Name:_____

Relation:_____

Phone #:_____

Have you ever had an orthodontic evaluation? ☐ Yes ☐No

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

Your current dental health is: ☐ Good ☐Fair ☐Poor

Do you like your smile? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

Have you ever had an injury to your: ☐Mouth ☐Teeth ☐Chin

Do you have any missing/extra permanent teeth? ☐Yes ☐No

Do you generally breathe through your mouth? ☐Yes ☐No

If yes: While awake? ☐Yes ☐No While asleep? ☐Yes ☐No

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

Dental History

General Dentist:_____

Date of Last Exam:_____

What are the main concerns that you would like orthodontics to accomplish?:_____

Medical History

Your current medical condition is ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician?

Physician's Name:_____

Are you taking an prescription/over-the-counter drugs?

☐Yes ☐No Please list:_____

Have you ever had any of the following diseases/medical problems?

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Anemia/Radiation Treatment
☐	☐	Asthma	☐	☐	Artificial Bones/Joint/Valve
☐	☐	Arthritis	☐	☐	Blood Transfusion
☐	☐	Cancer/Chemotherapy	☐	☐	Diabetes
☐	☐	Tuberculosis	☐	☐	Congenital Heart Defects
☐	☐	Difficulty Breathing	☐	☐	Glaucoma
☐	☐	Emphysema	☐	☐	Drug or Alcohol Abuse
☐	☐	Heart Murmur	☐	☐	Epilepsy/Seizures/Fainting
☐	☐	Hemophilia	☐	☐	Fever Blisters/Herpes
☐	☐	Hepatitis	☐	☐	Heart Surgery/Pacemaker
☐	☐	HIV+/AIDS	☐	☐	High/Low Blood Pressure
☐	☐	Hospitalization	☐	☐	Kidney Problems
☐	☐	Mitral Valve Prolapse	☐	☐	Psychiatric Problems
☐	☐	Shingles	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Sinus Problems	☐	☐	Severe/Frequent Headaches
☐	☐	Heart Attack	☐	☐	Ulcers/Colitis
☐	☐	Venereal Diseases	☐	☐	Are you Pregnant?

Please list any serious medical condition(s) that you have ever had:_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Tetracycline	☐	☐	Latex
☐	☐	Metals/Plastics	☐	☐	Dental Anesthetic	☐	☐	Other

Please list any other drugs/materials that you are allergic to:_____

Comments *(for office use only)*

Dr. Initials_____

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

Signature Date

Reviewed

Adventure Dental
Pediatric Dentistry and Orthodontics