ADULT

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PRACTICE LIMITED TO ORTHODONTICS FOR ADULTS AND CHILDREN

Patient's Name (print)____Email Address______________________________________

Address____Town_________________ Zip Code_____________________

Male ( ) Female ( ) Telephone: Home________________________Business_____________________Cell______________________

REFERRED BY____

Birth Date________________________Birthplace______________________ Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( )

Dentist's Name__________________________________of____________________________Date of Last Dental Checkup________

Physician's Name___________________________________ Date of Last Medical Checkup________________________________

Your Occupation____________________________________ Your Social Security # ______________________________________

Employer & Address ____

Spouse's Name___________________________________ Spouse's Occupation_______________________________________

Spouse's Employer & Address ____ Spouse's Birth Date____________________

Spouse's Social Security Number_______________________ Spouse's Telephone (Bus.) ________________(Cell)______________

Children's Names and Ages____

Are any family members currently in treatment? ____________ **If so, who?** ____

Currently wearing braces/Invisalign? ____________ **Wearing retainers?** __________**Has an appliance?** __________________

1.**WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?**

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2. Are you in good Health? Yes ( ) No ( ) 3. Do you have regular medical examinations? Yes ( ) No ( )

4. Have you ever had any of the following? Anemia ( ) Diabetes ( ) Asthma ( ) Epilepsy ( ) Hay Fever ( ) Hemophilia ( ) Hepatitis ( ) Hives ( ) Jaundice ( ) Pneumonia ( ) Heart Disease ( ) Migraines ( ) Liver or Kidney Disease ( ) Jaw pain or tenderness/TMJ ( ) Mouth Breather ( ) Face/Mouth/Tooth Injuries ( ) Rheumatic Fever ( ) Blood Disorders ( ) Chronic Headaches ( ) Fainting/Dizziness ( ) **ALLERGIES TO ANY DRUGS** ( ) Mitral Valve Prolapse ( ) Handicaps/Disabilities ( ) HIV/AIDS ( ) Cancer ( ) Hereditary background of dental problems?(i.e. underbite, overbite, gum recession/gum disease) ( )

5. Do you require pre-medication for any condition?___________________________If so, for what?______________________________

6. Is there anything else we should know about your general health? (i.e. allergies to foods, medications, **LATEX**

etc.)____

Signature:____ Today's Date: ________________________________