



ADULT ORTHODONTIC PATIENT INFORMATION

Patient Name _____ Age _____ Birthdate ____ - ____ - ____ Sex _____
 Street Address _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Business Phone _____
 Cell Phone _____ Fax _____
 E-Mail Address _____
 Person to notify in case of emergency: Name _____
 Telephone _____
 Referred by: _____

MEDICAL HISTORY

Has the patient ever had any of the following? If yes, please explain on reverse side.

Adenoid Removal	Y	N	Allergies	Y	N	Anemia	Y	N
Asthma	Y	N	Birth Defects	Y	N	Blood Disease	Y	N
Bone Disease	Y	N	Diabetes	Y	N	Drug Allergies	Y	N
Emotional Disorder	Y	N	Head & Face Injury	Y	N	Hearing Disorder	Y	N
Heart Disease	Y	N	Hepatitis	Y	N	Hormone Disorder	Y	N
Immune Disease	Y	N	Rheumatic Fever	Y	N	Tonsils Removal	Y	N

Is the patient currently under the care of a physician? No Yes If yes, please explain on reverse.
 Is the patient currently taking any drugs or medications? No Yes If yes, please explain on reverse.
 Is there any other medical problem not covered above? No Yes _____

DENTAL HISTORY

Name of Dentist _____ Date of Last Dental Exam _____
 Have you ever had previous orthodontic treatment? Yes No, ____ years ago
 Have you ever been treated for periodontal disease? Yes No, by Dr(s). _____
 Have any teeth been injured due to accident? Yes No _____
 Have you had any pain or clicking in the jaw joint? Yes No _____
 Have you had any difficult or unusual dental experiences? Yes No _____
 Have you had any dental problems not covered above? Yes No _____
 What is your chief reason for seeking this evaluation? _____

Signature _____ Date _____