ADULT INFORMATION FORM

DATE_____

BIRTH DATE_____ AGE_____

PATIENT'S NAME_____ NICKNAME_____ SEX_____

ADDRESS_____ CITY _____

STATE_____ ZIP_____ PHONE_____ CELL PH.:_____

SCHOOL_____ GRADE_____

PATIENT'S DENTIST_____ PHYSICIAN_____

REFERRED BY_____E-MAIL_____

NAMES OF CHILDREN IN FAMILY_____

SELF: NAME_____ OCCUPATION_____

EMPLOYED BY_____ BUS. PHONE_____

BUS. ADDRESS_____SOC.SEC. NO._____

DENTAL INSURANCE CO.?_____ ORTHO COVERAGE_____

HUSBAND / WIFE: NAME_____ OCCUPATION_____

EMPLOYED BY_____ BUS. PHONE_____

BUS. ADDRESS_____SOC.SEC. NO._____

DENTAL INSURANCE CO.?_____ ORTHO COVERAGE_____

MEDICAL/DENTAL HISTORY

DATE OF LAST DENTAL EXAM. MONTH_____ YEAR_____

IS PATIENT IN GOOD HEALTH_____ Yes ❑ No ❑

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS ?_____ Yes ❑ No ❑

PLEASE LIST_____ Yes ❑ No ❑

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE?_____ Yes ❑ No ❑

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS:_____ Yes ❑ No ❑

LIST ANY ALLERGIES OR DRUG SENSITIVITY:_____ Yes ❑ No ❑

WOMEN: ARE YOU PREGNANT? Yes ❑ No ❑

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?_____ Yes ❑ No ❑

IS THE PATIENT A MOUTH BREATHER?_____ Yes ❑ No ❑

IS THE PATIENT A FINGER OR THUMB SUCKER?_____ Yes ❑ No ❑

LIST ANY MUSICAL INSTRUMENTS PLAYED_____ Yes ❑ No ❑

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?_____ Yes ❑ No ❑

REASON FOR CONSULTATION_____

_____

DIABETES ❑ ANEMIA ❑ PROLONGED BLEEDING ❑ PNEUMONIA ❑ EPILEPSY ❑ FAINTING OR DIZZINESS ❑ HEART TROUBLE ❑ TUBERCULOSIS ❑

NERVOUS DISORDERS ❑ RHUEMATIC FEVER ❑ KIDNEY INVOLVEMENT ❑ LIVER INVOLVEMENT ❑ BONE DISORDERS ❑ ENDOCRINE PROBLEMS ❑

ASTHMA ❑ HEPATITIS ❑ ACQUIRED IMMUNE DEFICIENCY SYNDROME ❑ VENEREAL DISEASE ❑

_____

SIGNATURE OF PATIENT