ADULT PATIENT INFORMATION FORM

Welcome to our office...

Please assist us by completing the following questions:

DATE OF EXAM _____ 20____

AGE_____ SEX_____

PATIENT'S NAME_____

First *Middle Name* *Last*

DATE OF BIRTH_____ SOCIAL SECURITY # _____

RES. ADDRESS_____ CITY_____ ZIP_____ PHONE _____

PATIENT'S DENTIST_____ REFERRED BY_____

PHYSICIAN_____

NAMES OF OTHER MEMBERS OF YOUR FAMILY TREATED BY OUR OFFICE?_____

PERSON RESPONSIBLE FOR ACCOUNT_____ SOCIAL SECURITY #_____

First *Middle Name* *Last*

ADDRESS_____ CITY_____ ZIP_____

DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? YES ❑ NO ❑ NAME OF COMPANY _____

OCCUPATION_____ CELL PHONE_____

EMPLOYED BY_____ HOW LONG HELD _____

SPOUSES NAME_____ CELL PHONE_____

EMPLOYED BY_____ HOW LONG HELD_____ OCCUPATION_____

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
Diabetes	❑	❑	*Tuberculosis*	❑	❑	*Endocrine or Thyroid Disease*	❑	❑
Pneumonia	❑	❑	*Anemia*	❑	❑	*Prolonged Bleeding*	❑	❑
Heart Abnormalities	❑	❑	*Epilepsy*	❑	❑	*Liver Disease*	❑	❑
Rheumatic Fever	❑	❑	*Asthma*	❑	❑	*Fainting & Dizziness*	❑	❑
Bone Disorders	❑	❑	*Kidney Disease*	❑	❑	*Nervous Disorders*	❑	❑

	YES	NO	?
ARE YOU IN GOOD HEALTH?_____	❑	❑	❑
DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS?_____	❑	❑	❑
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS_____			
DO YOU HAVE ARTHRITIS_____	❑	❑	❑
DO YOU HAVE ANY HISTORY OF LATEX, METAL OR DRUG ALLERGIES/SENSITIVITIES_____	❑	❑	
DOES THE PATIENT NEED TO TAKE ANTIBIOTICS BEFORE TEETH CLEANINGS?_____	❑	❑	
HAVE WISDOM TEETH BEEN REMOVED? WHAT AGE:_____	❑	❑	
HAVE YOU SEEN A PHYSICIAN IN THE LAST 2 YEARS_____	❑	❑	
IF YES, WHY?_____	❑	❑	

DENTAL HISTORY

HAS THERE BEEN ANY INJURES TO THE FACE, MOUTH OR TEETH?_____	❑	❑	❑
IS THERE A FAMILY HISTORY OF MISSING OR EXTRA TEETH?_____	❑	❑	❑
DO YOU HAVE FREQUENT HEADACHES?_____	❑	❑	❑
HAVE YOU HAD ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS?_____	❑	❑	❑
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?_____	❑	❑	❑
HAVE YOU HAD A PREVIOUS ORTHODONTIC EXAMINATIONS?_____	❑	❑	❑
DO YOU CLENCH OR GRIND YOUR TEETH?_____	❑	❑	❑
HAVE YOU HAD ANY PERIODONTAL TREATMENT?_____	❑	❑	❑
DO YOU FEEL THAT YOU NEED ORTHODONTIC TREATMENT?_____	❑	❑	❑
ARE YOU APPREHENSIVE ABOUT ORTHODONTIC TREATMENT?_____	❑	❑	❑
WHEN DID YOU LAST SEE HIS/HER DENTIST?_____ WERE ANY X-RAYS TAKEN?_____	❑	❑	❑
WOULD YOU MIND WEARING BRACES_____	❑	❑	❑

LIST SPORTS AND INTERESTS_____

REASON FOR ORTHODONTIC EXAMINATION_____

_____

_____

Signature *Date*

Updated 20_____ Initialed _____

20_____ _____

20_____ _____

CENTRAL LAKES ORTHODONTICS, P.A.
TODD G. ANDERSON, D.D.S.