

Patient Information: Adult

Name: _____ Nickname: _____

Address: _____

How long at this address? _____ Sex: M F Email: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Birthdate: _____ Social Security: _____

Employer: _____ Years of employment: _____

Dentist: _____ Date of last cleaning: _____

How did you hear about us? _____

INSURANCE

Cardholder's name (if different from above): _____ Birthdate: _____

Insurance company name: _____

Insurance address: _____

Insurance phone: _____ Group name: _____

Insurance ID# or SS#: _____ Group ID#: _____

SECONDARY INSURANCE

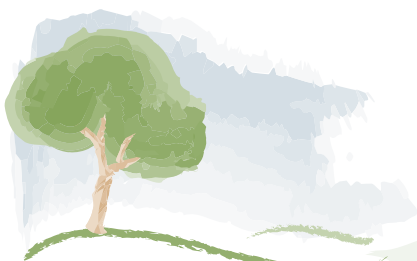
Cardholder's name (if different from above): _____ Birthdate: _____

Insurance company name: _____

Insurance address: _____

Insurance phone: _____ Group name: _____

Insurance ID# or SS#: _____ Group ID#: _____



(...continued)

GENERAL

Describe the primary concern with your teeth: _____

Y N Have you had any prior orthodontic consultation or treatment?

DENTAL

Y N Do you require antibiotics for dental cleanings?

Y N Are you aware of any dental work that needs to be completed (ie: fillings)?

Y N Are you presently in any dental pain?

Y N Have you ever had trauma to the head, face or teeth? (if yes, please circle answer)

Y N Do you have any extra, missing or extracted teeth? (if yes, please circle answer)

Y N Have you ever had an unfavorable reaction to dentistry?

Y N Do you have TMJ problems (clicking/pain)?

Y N Have your adenoids/tonsils been removed?

Y N Do you brush daily?

Y N Floss daily?

Y N Do you have any gum problems?

Y N Have a finger/thumb habit?

Y N Do you clench/grind your teeth?

Y N Have difficulty chewing?

Y N Do you have any speech problems?

Y N Use any tobacco products?

MEDICAL

Please check any problems or conditions that may apply to you:

Abnormal bleeding/Hemophilia

Epilepsy

Kidney

Anemia

Gastrointestinal

Psychological/ADD/ADHD

Asthma

Heart problem/defect

Rheumatic/Scarlet fever

Bone disorder

Heart murmur

Tuberculosis

Diabetes

Hepatitis/Liver

Tumor/Cancer

Drug/alcohol use

Herpes/Fever blisters

Other _____

Endocrine

HIV/AIDS

Females: Are you pregnant? Y N Week: _____

Do you have allergies to any medications or any other substance? _____

List all medications currently being taken: _____

I have read and understand the above questions, and this office's privacy policies. I will not hold Sandhills Orthodontics responsible for any errors or omissions. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes.

I understand, where appropriate, credit bureau reports may be obtained.

Signature

Date

