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...)

Glynda R. McConville, DDS, PA
SANDHILLS ORTHODONTICS

sandhillsortho.com
p: 919.718.9188 fax: 919.718.0900
1129 Carthage Street Sanford, NC 27330

(...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
○ Anemia
○ Asthma
○ Bone disorder
○ Diabetes
○ Drug/alcohol use
○ Endocrine
○ Epilepsy
○ Gastrointestinal
○ Heart problem/defect
○ Heart murmur
○ Hepatitis/Liver
○ Herpes/Fever blisters
○ HIV/AIDS
○ Kidney
○ Psychological/ADD/ADHD
○ Rheumatic/Scarlet fever
○ Tuberculosis
○ Tumor/Cancer
○ Other _____

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