ADULT PATIENT INFORMATION FORM

EXAM DATE ____ / ____ / ____ (MM / DD / YYYY)

PATIENT NAME ______ (LAST) ______ (FIRST) ______ (INITIAL) ☐Mr. ☐Miss ☐Ms. ☐Mrs. ☐Dr. DATE OF BIRTH ____ / ____ / ____ (MM / DD / YYYY)

ADDRESS ______ CITY ______ POSTAL CODE ______

PHONE NUMBER ______ E-MAIL ______ AGE ______ SEX ______

PATIENT'S OCCUPATION ______ EMPLOYED BY ______

ARE YOU FINANCIALLY RESPONSIBLE FOR YOUR OWN ACCOUNT? ☐ YES ☐ NO

DO YOU HAVE INSURANCE? ☐ YES ☐ NO IF YES, FILL OUT ATTACHED FORM.

IF YOU ANSWERED NO TO THE ABOVE TWO QUESTIONS, PERSON(S) RESPONSIBLE FOR ACCOUNT:

NAME ______ NAME ______

ADDRESS: ______ ADDRESS: ______

PHONE NUMBER: ______ PHONE NUMBER: ______

RELATIONSHIP TO YOU ______ RELATIONSHIP TO YOU ______

DO THEY HAVE INSURANCE? ☐ YES ☐ NO IF YES, FILL OUT ATTACHED FORM.

PATIENT'S DENTIST ______ PHYSICIAN ______

WHOM MAY WE THANK FOR REFERRING YOU? ☐ DENTIST ☐ PHONEBOOK ☐ FRIEND ☐ RELATIVE ☐ INTERNET ☐ OTHER ______

LIST ANY FAMILY MEMBERS THAT ARE PATIENTS IN OUR OFFICE ______

WHAT IS YOUR CHIEF CONCERN? WHAT BROUGHT YOU HERE? PLEASE BE SPECIFIC

______

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD:

YES	NO		YES	NO		YES	NO	
		ALZHEIMER'S DISEASE			EXCESSIVE THIRST			PERSISTENT COUGHING
		ANAPHYLAXIS			FAINTING SPELLS/DIZZINESS			PNEUMONIA
		ANEMIA			FREQUENT DIARRHEA			PROLONGED BLEEDING
		ANGINA			GLAND PROBLEMS			PSYCHIATRIC CARE
		ARTHRITIS			GLAUCOMA			RADIATION TREATMENTS
		ARTIFICIAL HEART VALVE			HAY FEVER			RECENT WEIGHT LOSS
		ARTIFICIAL JOINT			HEART ATTACK/FAILURE			RENAL DIALYSIS
		ASTHMA			HEART DISEASE			RHEUMATIC FEVER
		BLOOD DISEASE			HEART MURMUR			RHEUMATISM
		BLOOD TRANSFUSION			HEART PACE MAKER			SCARLET FEVER
		BONE DISORDER			HEMOPHILIA			SHINGLES
		BRUISE EASILY			HEPATITIS			SICKLE CELL DISEASE
		CANCER			HIGH BLOOD PRESSURE			SINUS TROUBLE
		CHEMOTHERAPY			HIVES OR RASH			SPINA BIFIDA
		CHEST PAINS			HYPOGLYCEMIA			STOMACH DISORDER
		CONVULSIONS			IMMUNE DEFICIENCY (HIV/AIDS)			STROKE
		CORTISONE MEDICINE			IRREGULAR HEARTBEAT			SWELLING OF LIMBS
		DO YOU SMOKE OR USE SMOKLESS TOBACCO?			KIDNEY DISEASE			THYROID DISEASE
		DIABETES			LEUKEMIA			TONSILLITIS
		DRUG ABUSE			LIVER DISEASE			TUBERCULOSIS
		EASILY WINDED			LUNG DISEASE			TUMORS OR GROWTHS
		EMOTIONAL DISORDER			LOW BLOOD PRESSURE			ULCERS
		EMPHYSEMA			MITRAL VALVE PROLAPSE			VENEREAL DISEASE
		EPILEPSY			PARATHYROID DISEASE			YELLOW JAUNDICE

YES	NO	
		DO YOU HAVE OR HAVE YOU EVER HAD ANY DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED ABOVE? SPECIFY: ______

WHAT IS YOUR PRESENT HEALTH? ☐ GOOD ☐ FAIR ☐ POOR

		ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR DRUGS? SPECIFY: ______

TURN OVER ➦

YES	NO	
☐	☐	DO YOU HAVE ANY ALLERGIES OR DRUG SENSITIVITY? SPECIFY: ______
☐	☐	IS YOUR PHYSICIAN CURRENTLY TREATING YOU FOR ANY CONDITIONS?
☐	☐	DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS? SPECIFY: ______
☐	☐	HAVE YOU HAD TONSILS OR ADENOIDS REMOVED? AT WHAT AGE? ______

LIST SPORTS, HOBBIES AND INTERESTS ______

DENTAL HISTORY

HAVE YOU HAD PREVIOUS ORTHODONTIC CARE OR CONSULTATION? ☐ YES ☐ NO

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

YES	NO	
☐	☐	ANY INJURIES TO THE: ☐ FACE ☐ MOUTH ☐ TEETH
☐	☐	TOOTHACHE
☐	☐	TEETH SENSITIVE TO ☐ HOT ☐ COLD
☐	☐	GUM DISEASE
☐	☐	LUMPS OR SORES IN MOUTH
☐	☐	HERPES/APTHOUS ULCERS
☐	☐	SPEECH PROBLEMS?
☐	☐	HAVE YOU EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? ______
☐	☐	ARE YOU A MOUTH BREATHER? ☐ WHILE AWAKE ☐ WHILE A SLEEP
☐	☐	ARE YOU AWARE OF ANY : ☐ MISSING TEETH ☐ EXTRA PERMANENT TEETH

HAVE YOU EVER HAD ANY PROBLEMS OR SIDE EFFECTS ASSOCIATED WITH PREVIOUS DENTAL CARE? ☐ YES ☐ NO

WHEN DID YOU LAST HAVE DENTAL EXAM AND CLEANING? ______

ARE THERE ANY FILLINGS/CROWNS STILL TO BE DONE? ☐ YES ☐ NO IS THE APPOINTMENT SCHEDULED? ☐ YES ☐ NO

IF YES, DATE: ______

TMJ

YES	NO	
☐	☐	DO YOU CLENCH OR GRIND YOUR TEETH?
☐	☐	DO YOU EVER HEAR: ☐ CLICKING ☐ GRINDING SOUNDS IN YOUR JAW JOINT? ☐ LEFT ☐ RIGHT
☐	☐	HAVE YOUR JAWS EVER LOCKED: ☐ OPEN? ☐ CLOSED?
☐	☐	DO YOU GET FREQUENT: ☐ HEADACHES? ☐ SORE FACIAL MUSCLES?
☐	☐	DO YOU WANT ORTHODONTIC TREATMENT IF INDICATED?

PATIENT/PARENT/GUARDIAN SIGNATURE ______ DATE ______

OFFICE USE ONLY

TC NOTES ______

CLINICAL OBSERVATIONS ______

ESTIMATED: COST ______

TIME ______

PROVISIONAL TREATMENT PLAN ______