A B C

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Previous Address (If less than 3 years) _____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate_____ Work Phone _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____Birthdate _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____Birthdate _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Phone _____

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

Signature _____

Updates (date & initial) _____

Name_____ **Date** _____

MEDICAL HISTORY

Physician_____ Date of Last Visit_____

Address_____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? List: _____
Yes No Are you allergic to any medication? List: _____
Yes No Do you have a history of a major illness? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant? _____
Yes No Has menstruation started? _____
Yes No Have you or are you taking any prescriptions for osteoporosis (Fosamax, Boniva, Actonel)? ____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Psychiatric Disorders
Anemia	Dizziness	Herpes	Radiation/Chemotherapy
Asthma or Hayfever	Epilepsy	High Blood Pressure	Rheumatic Fever
Bone Disorders	Heart Murmur	HIV / Aids	Tuberculosis
Congenital Heart Defect	Heart Problems	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist_____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Are you aware that some appointments will be during work hours? _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. In addition, I authorize Dr. Jennifer Yau to perform a complete orthodontic evaluation

Signature:_____ Date:_____

Dr. Signature:_____ Date:_____