ADULT PATIENT INFORMATION

Exam Date_____/_____/_____

Patient's Name_____ ☐ M ☐ F Nickname_____
Last First Middle

Birthdate_____/_____/_____ Age_____ SSN_____-_____-_____

Address_____
Street City State Zip

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

RESPONSIBLE PARTY INFORMATION

Name_____ Marital Status_____
Last First Middle

Address_____
Street City State Zip

How long at this address?_____ Home Ph_____ Cell/W Ph_____ Email_____

Previous Address (if less than 3 yrs)_____
Street City State Zip

Birthdate_____/_____/_____ SSN_____ - _____ - _____ Occupation_____ Relationship to Patient_____

Employer_____ Address_____
Street City State Zip

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Birthdate_____/_____/_____ SSN_____ - _____ - _____ Occupation_____ Cell/W Ph_____

Employer_____ Address_____
Street City State Zip

INSURANCE INFORMATION AND AUTHORIZATION

Insured's Name_____ _____ Insured's SSN_____

Insurance Company_____ Group Number_____

Ins Company Address_____ Phone_____

Insured's Employer_____ Secondary Coverage? ☐ Y ☐ N

If Yes: Insured's Name_____ Insured's SSN_____

Insurance Company_____ Group Number_____

Ins Company Address_____ Phone_____

Insured's Employer_____

I assign directly to Dr. Nguyen my insurance benefits for services rendered. I hereby authorize the Doctor and Staff to release information necessary to secure payment of benefits, and authorize the use of this signature on insurance submissions.

Signature_____ Date_____/_____/_____

EMERGENCY INFORMATION

Person to notify in an emergency:_____ Phone_____

Complete Address_____

ADULT HEALTH QUESTIONAIRE

Patient's Name_____ Date_____

What is your chief concern—please be specific?_____

Physician_____ Dentist_____ Date of last dental exam_____

Who first noticed the need for an orthodontic examination? ☐ Dentist ☐ Patient

DENTAL HISTORY

			EXPLANATION
Has anyone in your family ever had orthodontic treatment?	Y	N	_____
If so, has the result been stable and satisfactory?	Y	N	_____
Are you concerned about the appearance of your teeth?	Y	N	_____
Are you worried about receiving orthodontic treatment?	Y	N	_____
Have you had previous orthodontic treatment or consultation?	Y	N	_____
Have you had previous periodontal (gum) treatment?	Y	N	_____
Do you have any loose or shifting teeth?	Y	N	_____
Have you had any permanent teeth removed?	Y	N	_____
Have you had your wisdom teeth removed?	Y	N	_____
Do you have problems with food trapped between teeth?	Y	N	_____
Do you have difficulty with chewing and swallowing food?	Y	N	_____
Do you have any speech problems?	Y	N	_____
Did you have a thumb or finger sucking habit? If yes, until what age?	Y	N	_____
Do you bite your lips, tongue, fingernails, pencils, or other objects?	Y	N	_____
Do you breathe through the mouth?	Y	N	_____
Do your gums bleed easily?	Y	N	_____
Are your teeth sensitive to hot or cold?	Y	N	_____
Have you ever received a severe blow to the teeth or jaws?	Y	N	_____
Have there been any other injuries to the face, mouth, or teeth?	Y	N	_____
Do you have frequent earaches or soreness around the ears?	Y	N	_____
Do you clench or grind your teeth?	Y	N	_____
Has your jaw ever locked open or closed?	Y	N	_____
If so, when did it first occur?	Y	N	_____
Do you consider yourself to be under more stress than most people?	Y	N	_____
Do you have difficulty in opening mouth wide?	Y	N	_____
Do you play a musical instrument? If so, which instrument?	Y	N	_____
Does any other family member have a similar bite problem as yourself?	Y	N	_____

MEDICAL HISTORY

			EXPLANATION
Are you in good health?	Y	N	_____
Do you have any allergies or drug sensitivities? Please explain	Y	N	_____
Do you have a tendency to colds, sore throat, or ear infections?	Y	N	_____
Have tonsils and adenoids been removed? At what age?	Y	N	_____
Any drug or medications now being taken? If so, please list	Y	N	_____
Do you require pre-medication with antibiotics for dental work?	Y	N	_____
Is there any other health condition that Dr. Nguyen should know about?	Y	N	_____

Do you have any difficulty with or history of any of the following: PLEASE CHECK IF YES.

_____AIDS/HIV	_____Diabetes	_____Hearing	_____Nervous Disorders
_____Anemia	_____Endocrine Problems	_____Heart Disease	_____Rheumatic Fever
_____Asthma or Hay Fever	_____Epilepsy	_____Heart Murmur	_____Thyroid
_____Bleeding Disorders	_____Fainting or Dizziness	_____Hepatitis or Liver Disease	_____Tuberculosis
_____Chronic Sinus	_____Glaucoma	_____Kidney	_____Vision
_____Convulsion	_____Headaches	_____Learning Disability	_____Other_____

I acknowledge all of the information given is to the best of my knowledge.

Patient Signature:_____ Dr. Signature: _____

Patients in active treatment: Please initialize if there is no change in your medical history:
One-year update:_____Date:_____
Two-year update:_____Date:_____