Adult Patient Form

Name: _____ Birthdate: _____ Age: _____ Sex: _____
Home Address: _____ City & Zip: _____
Mailing Address (if different): _____
Employed By: _____ Job Title: _____
Work Address: _____
Home Phone: _____ Work Phone: _____
Dentist: _____ Last Visit: _____ Referred By: _____ _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Remarried ☐ Widowed
Spouse's Name: _____ Birthdate: _____
Address (if different): _____
Employed By: _____ Job Title: _____
Work Address: _____ Work Phone: _____

Medical History

Have you been diagnosed with or treated for any of the following conditions?

☐ Diabetes
☐ Epilepsy
☐ Polio
☐ Arthritis
☐ Asthma
☐ Tuberculosis
☐ Rheumatic fever
☐ Heart murmur
☐ Heart condition
☐ Anemia
☐ Prolonged bleeding
☐ Hepatitis
☐ Gastro-intestinal
☐ Cerebral palsy
☐ Emotional problems
☐ Endocrine disorders
☐ Bone disorders
☐ Fainting/dizziness
☐ Tonsils removed
☐ Adenoids removed

YES NO

◯ ◯ Are you presently under a physician's care?
For: _____
_____

◯ ◯ Are you taking any pills, medications, or drugs?
_____
_____

◯ ◯ Have you ever had an unusual reaction to medication? _____
_____

◯ ◯ Are you allergic to anything? _____
_____
_____

◯ ◯ Do you have a tendency to:
Colds _____
Sore throats _____
Ear infections _____

◯ ◯ Have you had any major surgery?
For: _____

◯ ◯ Do you have a chronic problem with:
Kidneys _____
Lungs _____
Liver _____

◯ ◯ Do you have any other medical problems not mentioned above? _____
_____

Dental History

YES NO

◯ ◯ Have you experienced any unfavorable reaction from any previous dental treatment that you are aware of?
◯ ◯ Do you breathe predominantly through the mouth?
◯ ◯ Do you have any speech problems?
◯ ◯ Do you clench or grind teeth?
◯ ◯ Do you have pain or clicking when closing your mouth?
◯ ◯ Have you had any severe head or face injuries?
When? _____
◯ ◯ Have any teeth been injured or chipped?
When? _____

◯ ◯ Any noticeable difficulty chewing or swallowing?
◯ ◯ Do you have any extra or missing teeth?
◯ ◯ Have any teeth been removed by extraction?
Why? _____
◯ ◯ Have you ever used a retainer or space maintainer?
◯ ◯ Has anyone in your family needed orthodontics?
◯ ◯ Have you had any previous orthodontic consultation or treatment?
◯ ◯ Would you mind wearing:
Braces? _____
Headgear? _____
◯ ◯ Do you want your teeth straightened?

I have examined the above information and it is true and correct.
Signature: _____ Date: _____