A SMILE BY DESIGN

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Specialist in Orthodontics

NEW PATIENT INFORMATION

ADULT PATIENT

Name: _____
Last ***First***

I Prefer to be called: _____

Birthdate: _____/_____/_____ ***Age:*** _____

Single____ ***Married***____ ***Divorced*** _____ ***Widowed*** ____ ***Separated***____

Home Phone: _____ ***Work:*** _____ ***Ext*** _____

Cell : _____ ***Email:*** _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____

Occupation: _____

Employer: _____

Name of Spouse: _____

Work phone: _____ ***Ext***_____ ***Cell:*** _____

Employer: _____

Other family members seen by us? _____

General Dentist: _____ ***Date of last visit*** _____

Whom may we thank for referring you? _____

Person Responsible for Account

Name: _____

Billing Address: _____

Home Phone: _____ ***Cell:*** _____

Employer: _____ ***Work Phone:*** _____

SS No. _____

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Medical History

Please check if the patient has or has had any of the following:

__Heart trouble
__Heart murmur/heart defect
__Artificial valves/pacemaker
__Rheumatic fever
__HIV+ / AIDS
__Hepatitis
__Tuberculosis
__Abnormal bleeding
__Diabetes
__Thyroid problems
__Kidney or liver problems
__Asthma/difficulty breathing
__Bone/joint disorders
__Osteoporosis or Bisphosphonate use
__Emotional problems
__Epilepsy/seizures
__Neurologic problems
__Sinus problems
__Tonsils/adenoids removed
__Cancer
__Use of cigarettes, cigars or smokeless tobacco
__Severe/frequent headaches
__Birth defects
__Adopted

Is the Patient currently under the care of a physician? _____
Physician's name: _____
List drugs or medications now being taken: _____
List any serious illnesses or operations: _____
List any allergies: _____

Dental History

Please check if the patient has or has had any of the following:

__Any injuries to face, mouth or teeth
__Thumb/ finger sucking
__Mouth breather
__Any missing permanent teeth
__Any extra permanent teeth
__Teeth removed by extraction
__Tongue thrusting problem
__Speech problems
__ Jaw joint problems
__Clenching or grinding teeth
__Bleeding gums/gum recession

Does patient brush his/her teeth daily? Yes No
Does patient floss his/her teeth daily? Yes No

What would you like to have orthodontic treatment accomplish? _____
_____

Has an orthodontist been consulted previously? _____
Reason: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature ***Date***