FAMILY ORTHODONTICS of Dublin

Patient Information *Adult*

First Name:_____ Last Name: _____ Birthdate:_____ Age:___ Sex: ☐ M ☐ F

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

What is your preferred choice for appointment confirmations? ☐ Home Phone ☐ Cell Phone ☐ Email

Social Security #_____-_____-_____ Driver's Lic #_____

Hobbies/Interests:_____

Please list any family member that has been a patient in our office:_____

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

Dentist Name:_____ Phone:_____ City:_____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Remarried

Your employer:_____ Occupation:_____

Address:_____City:_____ Zip:_____

Work Phone:_____

Name of Emergency Contact:_____

Relationship: ☐ Spouse/Partner ☐ Parent ☐ Sibling ☐ Friend ☐ Other: _____

Address:_____City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Dental Insurance

Your Dental Insurance:_____ Insurance Phone: _____

Group #_____ Subscriber's ID: _____

Spouse's Dental Insurance:_____ Insurance Phone: _____

Name of Spouse (if not listed above):_____

Group #_____ Spouse's Subscriber's ID: _____

Spouse's Birthdate: _____ and/or Spouse's Social Security #_____-_____-_____

Medical History

Do you currently have or have you ever had any of the following (*please circle yes or no*):

Arthritis	Yes	No	Epilepsy	Yes	No	Metal Allergy	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Mouth Breathing	Yes	No
Back or Neck problems	Yes	No	Head/brain injury	Yes	No	Nervous disorders	Yes	No
Bleeding disorder	Yes	No	Heart murmur	Yes	No	Periodontal (Gum) Problems	Yes	No
Bone disorder	Yes	No	Heart problems	Yes	No	Rheumatic Fever	Yes	No
Bulimia	Yes	No	Hepatitis	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Tooth Grinding	Yes	No
Chest Pains	Yes	No	Jaw or Jaw joint Pain	Yes	No	Trauma to face/teeth	Yes	No
Diabetes	Yes	No	Latex Allergy	Yes	No	Tuberculosis (TB)	Yes	No

(Continued on back)

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Medical History *(continued)*

Do you have any disease, problem, or illness not mentioned above? ☐ No ☐ Yes, please specify: _____

_____

Do you currently take any drugs or medications? ☐ No ☐ Yes, please list: _____

_____

Do you have any allergies? ☐ No ☐ Yes, please specify: _____

_____

Physician: _____ Phone:_____ City:_____

Last date seen by physician: _____

Women: Are you pregnant?	Yes	No
Do you smoke? If yes, how many cigarettes do you smoke per day?_____	Yes	No
Have you ever taken any bisphophonate drugs (Fosamax, Actonel, Boniva)?	Yes	No
Do you have any breathing problems?	Yes	No

Dental History

When was your last dental examination?_____ When was your last cleaning?_____

How often do you brush your teeth? _____ How often do you floss?_____

Do your gums bleed when you brush or floss? ☐ Always ☐ Occasionally ☐ Never ☐ Other: _____

Please describe your reason(s) for choosing to seek orthodontic treatment: _____

_____

Do you have any pain or noises while opening or closing your mouth?	Yes	No
Are you aware of any missing teeth?	Yes	No
Are you aware of any extra teeth?	Yes	No
Are you aware of any tongue-thrust problems?	Yes	No
Have you consulted with another orthodontist about your problem?	Yes	No
Have you had previous orthodontic treatment?	Yes	No
Are you happy with the way your teeth look now?	Yes	No
Are you happy with the way your profile looks now?	Yes	No
Are you willing to wear metal braces to help straighten your teeth?	Yes	No
Are willing to wear ceramic (tooth-colored) braces to help straighten your teeth?	Yes	No

I, _____ authorize this facility to examine and provide orthodontic treatment. I accept full responsibility for any balance due. I authorize my insurance company to make payments directly to this facility when applicable. I understand it is my responsibility to know all the rules and restrictions of my insurance policy including orthodontics. I authorize this facility to release any dental or incidental information that may be necessary for either dental care or in processing application for financial benefit. I understand that this office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Patient Signature:_____ **Date**_____

(Rev.010411)