Date: ___/___/___

A B C

Allergy Alert

ADULT PATIENT INFORMATION

Patient's Name: _____Birthdate:___/___/___ Age: _____ ☐Male ☐Female
Preferred Name/Nickname:_____
Address:_____City_____State_____Zip_____
How long? _____ Rent or Own? (Circle one)
Previous address if above is less than 3 years: _____City_____State_____Zip_____
SSN: _____/_____/_____ E-Mail: _____
Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Home Phone: ( ) _____-_____

Employer Name: _____Occupation:_____ # of years employed:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Other:_____

Spouse's Name:_____ Birthdate: ___/___/___ SSN: _____/_____/_____
Employer Name: _____Occupation:_____ # of years employed:_____
Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____
Whom may we thank for referring you to the office?
My dentist:_____
Friend/Family Member:_____
Other:_____

Other Family Members Seen By Us: _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name: _____ Birthdate: ___/___/___ SSN: _____/_____/_____
Insurance Company:_____
Group #: _____ Policy #:_____
Insurance Company Address:_____City_____State_____Zip_____
Ins. Co. Phone #: ( ) _____-_____

Dual Coverage: Yes or No. If yes, please fill out below:

Insured's Name: _____ Birthdate: ___/___/___ SSN: _____/_____/_____
Insurance Company:_____
Group #: _____ Policy #:_____
Insurance Company Address:_____City_____State_____Zip_____
Ins. Co. Phone #: ( ) _____-_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Phone: ( ) _____-_____

Complete Address:_____City_____State_____Zip_____
Previous Address if above is less than 3 years: _____ City_____State_____Zip_____
As the responsible party, I hereby agree to provide payment for all services not covered by insurance.

Signature:_____ Date:_____

MEDICAL HISTORY

Physician Name: _____ Date of Last Visit: _____
Physician Address: _____Physician Phone: ( ) _____-_____

Please circle yes or no for the following questions and provide additional details as necessary:

Yes No Are you taking any medication? If so, what?_____
Yes No Are you allergic to any medication? Latex? If so, what?_____
Yes No Do you have a history of major illness? If so, please describe:_____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? List any reasons other than annual checkup. _____
Yes No Are you pregnant? If so, due date:_____
Yes No Have you been advised to take antibiotics prior to dental appointments? If so, Why? _____

Please circle any of the medical conditions below that you have had or currently have:

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

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

DENTAL HISTORY

General Dentist Name:_____
Date of last visit:_____ Have you had your teeth cleaned in the last 12 months? Yes No
What concerns you most about your teeth?_____

Please circle yes or no for the following questions and provide additional details as necessary:

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 permanent teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? If so, where? (Upper, lower, left, right, etc…) _____
Yes No Is any part of your mouth sensitive to pressure? If so, where? (Upper, lower, left, right, etc…) _____
Yes No Do your gums bleed when you brush? _____
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 Has anyone in your family received orthodontic treatment? How did they feel about the result? _____
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 you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____

Describe any other dental concerns you have:
_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. J. Lawrence Hutta and Dr. Brandon Cook to perform a complete orthodontic evaluation. Please be aware that some appointments will be during work hours.

Signature:_____ Date:_____
Health history updated:
Date:_____ Date:_____ Date:_____ Date:_____