AmericanRiverOrthodontics.com

Adult Patient Information Form
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Orthodontics for Children & Adults

(Please Print)
Name _____ I prefer to be called_____
Address _____ City _____ Zip _____
Home Phone _____ Work Phone _____Cellular phone _____
Birth date _____ Age _____ Sex _____ Your Occupation _____
Employed by_____
Business Address _____ City _____ Zip _____
Are you . . . . . □Married □Single □Divorced □Separated
How did you hear about us?_____

Spouses Name _____ Employed by _____
Occupation _____ Business phone_____
Business Address _____ City _____ Zip _____
Person Financially Responsible_____ Relationship to patient _____
Address _____ City _____ Zip _____

Insurance
Is the patient covered by insurance for orthodontic treatment? □Yes □No
Primary Dental Carrier_____ Group # _____

Insured Name _____ Birth date _____ Soc.Sec.#_____

Secondary Dental Carrier _____ Group # _____

Secondary Insured Name_____ Birth date _____Soc.Sec.#_____

Do you anticipate a move or transfer in the near future yes / no
Names and ages of children in your family? _____
Musical instruments played_____Sports_____Hobbies_____

MEDICAL HISTORY

Patient's Physician _____
Most recent physical examination _____
Any changes in health in the last year □yes □no (If yes explain) _____
Any operations, accidents, or hospitalizations? □yes □no (If yes explain) _____
List any medications, nutrient supplements or non prescription medicine taken now or in the past? □yes □no
(If yes explain) _____
List drug sensitivities, reactions to dental anesthetics, or any allergies _____

□**yes** □**no** Birth defects or hereditary problems?
□**yes** □**no** Rheumatoid or arthritic conditions?
□**yes** □**no** Endocrine or thyroid problems?
□**yes** □**no** Kidney problems?
□**yes** □**no** Diabetes?
□**yes** □**no** Cancer or treated for a tumor?
□**yes** □**no** Hepatitis, jaundice or liver problem?
□**yes** □**no** AIDS or HIV Positive?
□**yes** □**no** Sexually transmitted disease?
□**yes** □**no** Fainting spells, seizures, epilepsy or neurological disease?
□**yes** □**no** Mental health or behavioral problems?
□**yes** □**no** Vision, hearing, tasting or speech difficulties?
□**yes** □**no** Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
□**yes**□ **no** High or low blood pressure?
□**Yes** □**no** Cardiovascular problems (heart trouble, stroke, heart defects or rheumatic heart?)

□**yes** □**no** Any history of speech problems?
□**yes** □**no** Eye, ear, nose, throat condition?
□**yes** □**no** Hay fever, asthma, sinus trouble, hives?
□**yes** □**no** Tonsil or adenoid conditions?
□**yes** □**no** Allergies or drug reactions?
□**yes** □**no** Do you currently have or ever had a substance abuse problem?
□**yes** □**no** Tuberculosis or other communicable disease
□**yes** □**no** Other physical problems or symptoms?
□**yes** □**no T**reatment for any conditions not listed above?

Female Patient
□**yes** □**no** Are you pregnant?
□**yes** □**no** Are you taking birth control pills?
□**yes** □**no** Are you anticipating becoming pregnant?

Please describe any illnesses or conditions circled yes above including when contracted and whether currently under treatment:

_____

Dental History

Dentist _____ Date of most recent dental exam _____

How often do you see your dentist? Every . . . . . □3 month's □6 month's □9 month's □1 year

□ **yes** □ **no** Chipped or otherwise injured permanent teeth?
□ **yes** □ **no** History of decayed or abscessed teeth?
□ **yes** □ **no** Teeth sensitive to hot or cold; teeth throb or ache?
□ **yes** □ **no** Supernumerary (extra) or congenitally missing teeth?
□ **yes** □ **no** Have teeth been removed by the dentist?
□ **yes** □ **no** Jaw fractures, cysts, mouth infections?
□ **yes** □ **no** Cold Sores, Cankers sores, other mouth ulcerations?
□ **yes** □ **no** Periodontal "Gum Problems" gum pocketing?
□ **yes** □ **no** Haver you ever had periodontal (gum) surgery treatment?
□ **yes** □ **no "TMJ"** (jaw joint) problems or facial muscle pain)?
□ **yes** □ **no** Tooth grinding, jaw clenching, clicking, locking?
□ **yes** □ **no** Any pain in jaw or ringing in the ears?
□ **yes** □ **no** Difficulty chewing, jaw opening or closing with pain
□ **yes** □ **no** Thumb, finger, or sucking habit?
□ **yes** □ **no** Mouth breathing habit, snoring, difficulty in breathing?
□ **yes** □ **no** Have you ever sucked a thumb or finger
□ yes □ no Has a orthodontist been consulted previously? If Yes, when was the previous orthodontics examination? _____
□ yes □ no Have you had orthodontic treatment? If yes, at what age_____ and for how long _____
□ **yes** □ **no** Have you recently been under another dentist's care? If yes, please list dentist specialty and treatment _____
_____

What brings you to our office?

_____
_____
_____
_____
_____
_____
_____

We wish to inform you in advance that as part of our routine business procedure, our office contracts with Equifax to conduct a cursory credit history on the responsible party for each of our patients prior to treatment.

Realizing that successful treatment greatly depends upon the your complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. **If there are any changes later to this history record or medical/dental status, I will so inform this practice.**

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Reviewed of medical and dental history

Changes □Yes □No If Yes describe_____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Changes □Yes □No If Yes describe_____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____