

ADULT

Date: _____ Name: _____
Social Security #: _____ Age: _____ Date of Birth: _____ Gender: _____
Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced
Dentist: _____ Referred By: _____
Address: _____
City: _____ State: _____ ZIP: _____ Home Phone: _____
E-mail Address: _____ Cell Phone: _____
Driver's Lic #: _____ Occupation: _____
Employed By: _____ City: _____ Work Phone: _____
Spouse's Name: _____ Social Security #: _____
Occupation: _____ Employed By: _____
City: _____ Work Phone: _____

INSURANCE INFORMATION

Do you have Orthodontic Insurance? ___ Yes ___ No If so, Company Name: _____
Address: _____ Group #: _____
City: _____ State: _____ ZIP: _____ Phone: _____

MEDICAL HISTORY

Physician's Name & Address: _____
Date of last physical exam: _____ Height: _____ Weight: _____
Have you or are you now under a physician's care for a health care problem? ___ Yes ___ No
If so, for what? _____
Have you been hospitalized in the last 5 years? ___ Yes ___ No If so, for what? _____
What medicines are you currently taking? _____
What operations have you had in the past? _____
Any known prescription drug allergies? _____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Allergies to penicillin | <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Severe weight loss |
| <input type="checkbox"/> Allergies to local anesthesia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Diabetes (sugar in blood) |
| <input type="checkbox"/> Allergies to food or drugs | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Neck pain or swelling | <input type="checkbox"/> Hepatitis (yellow jaundice) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fatigue easily | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Prolonged bleeding from surgery | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Visual problems (glasses?) | <input type="checkbox"/> Steroid therapy (cortisone) |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent illness or infections | <input type="checkbox"/> Drug dependence |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bloody cough | <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Headaches | <input type="checkbox"/> X-ray or cobalt therapy | <input type="checkbox"/> Women: Are you pregnant? |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Slow healing | <input type="checkbox"/> Other physical condition |