ADULT PATIENT INFORMATION

Patient's name _____ Sex: □ Male □Female
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone_____Work phone_____

Cell Phone_____ Birthdate _____ Social Security #_____

Email Address_____ _____Marital Status: Single__ Married__ Widowed__ Separated__ Divorced

Employer_____ Occupation _____

Spouse's Name_____ Spouse's Employer _____Spouse's Phone _____

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

Is there a specific time of the day or week when you must be seen? _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insured's Birthdate _____ Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insured's Birthdate _____ Insurance Company_____ Group No _____

Insurance Co. Address_____Phone No _____

X-RAY INFORMATION

It is necessary to take x-rays periodically throughout the orthodontic treatment process. If you have any questions or concerns please let us know.

EMERGENCY INFORMATION

Name of nearest relative not living with you _____Phone No _____

Payment for services is the responsibility of the patient.

In the event you have Orthodontic dental insurance, we will accept direct assignment of benefits if such benefit coverage's can be pre-determined. We will be happy to assist in the preparation of insurance forms.

Signature: _____ Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Have you ever taken bisphosphonates (Fosamax, Actonel, etc)_____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident?_____
Yes No Have you ever smoked or chewed tobacco?_____
Female Patients only:
Yes No Are you pregnant? _____

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 or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Artificial Joints or Limbs	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

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

Circle any of the allergies or adverse reactions you may have had to the following:

Penicillin	Local Anesthetic	Other Antibiotics	Aspirin
Ibuprofen	Codeine	Latex	Other: _____

DENTAL HISTORY

Dentist _____ Date of last visit _____

What concerns you most about your teeth (too big/small, too long/short, spaces, crooked, crowded, gummy, etc)?
_____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to hot/cold/pressure? Where? _____
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?_____
What is your attitude toward receiving orthodontic treatment? _____
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 that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____

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. Kim to perform a complete orthodontic evaluation which includes digital photographs and x-rays.

Signature: _____Date: _____