Associated Orthodontists EST. 1969

FOR ADULTS: WELCOME TO OUR PRACTICE

Date: _____ OPMS#: _____

Doctor: **CY** **D** **S** **P**

Location: **J** **F** **M** **P** **B** **NL**

Exam With: _____

PATIENT INFORMATION

PATIENT NAME: _____ SS#: _____ DOB: _____ AGE: _____

PREFERRED NAME: _____ EMAIL: _____ MALE ❑ FEMALE ❑

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE (____) _____ CELL (____) _____ CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____

SCHOOL/EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

HOBBIES/SPECIAL INTERESTS: _____

NAME OF GENERAL DENTIST: _____ PHONE : (_____) _____

NAME OF OTHER FAMILY MEMBERS TREATED AT ASSOCIATED ORTHODONTISTS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ADDITIONAL RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATIONSHIP: _____

BIRTHDAY: _____ SS#: _____ ADDRESS: _____

EMAIL: _____ PHONE: (____) _____ CELL: (____) _____

CELL PHONE CARRIER (I.E. VERIZON, AT&T): _____

EMPLOYER: _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE PHONE: _____

GROUP/POLICY #: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

SS#/ID#: _____

INSURED'S EMPLOYER: _____

PLEASE COMPLETE SIDE 2

PATIENT DENTAL/MEDICAL HISTORY

FOR WOMEN ONLY

ARE YOU PREGNANT? ❑ YES* ❑ NO **WEEK #:** _____

IF YES, PLEASE NOTIFY US PRIOR TO X-RAYS BEING TAKEN.

ARE YOU TAKING BIRTH CONTROL PILLS? ❑ YES ❑ NO

ARE YOU NURSING? ❑ YES ❑ NO

WHY HAVE YOU COME TO THE ORTHODONTIST TODAY? _____

_____

DO YOU LIKE YOUR SMILE? _____ ❑ YES ❑ NO

ARE YOU CURRENTLY IN PAIN? _____ ❑ YES ❑ NO

YOUR CURRENT DENTAL HEALTH IS: _____ ❑ GOOD ❑ FAIR ❑ POOR

HAVE YOU EVER HAD ANY SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK?

_____ ❑ YES ❑ NO

HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT? _____ ❑ YES ❑ NO

HAVE YOU EVER HAD ANY TRAUMA TO THE MOUTH OR JAW JOINT? _____ ❑ YES ❑ NO

PLEASE DESCRIBE TRAUMA: _____

_____

DO YOU HAVE A MOUTH BREATHING HABIT? _____ ❑ YES ❑ NO

DO YOU HAVE A HABIT OF SNORING? _____ ❑ YES ❑ NO

DO YOU HAVE TOOTH SENSITIVITY? _____ ❑ YES ❑ NO

DO YOU CLENCH OR GRIND YOUR TEETH? _____ ❑ YES ❑ NO

DO YOUR GUMS EVER BLEED? _____ ❑ YES ❑ NO

HOW MANY TIMES A WEEK DO YOU FLOSS? _____

HOW MANY TIMES A WEEK DO YOU BRUSH? _____

TYPES OF BRISTLES: _____ ❑ HARD ❑ MEDIUM ❑ SOFT

DO YOU HAVE A PERSONAL PHYSICIAN? _____ ❑ YES ❑ NO

NAME: _____ PHONE #: _____

YOUR CURRENT PHYSICAL HEALTH IS: _____ ❑ GOOD ❑ FAIR ❑ POOR

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR? _____ ❑ YES ❑ NO

EXPLAIN: _____

ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ ❑ YES ❑ NO

LIST: _____

_____

YES	NO		YES	NO	
❑	❑	HEART MURMUR	❑	❑	CONGENITAL HEART DEFECT
❑	❑	CANCER	❑	❑	CONVULSIONS/EPILEPSY
❑	❑	DIABETES	❑	❑	ABNORMAL BLEEDING
❑	❑	RHEUMATIC FEVER	❑	❑	HEARING IMPAIRMENT
❑	❑	HIV+/AIDS	❑	❑	ANY OPERATIONS
❑	❑	HEMOPHILIA	❑	❑	ANY STAYS IN HOSPITAL
❑	❑	ASTHMA	❑	❑	HANDICAPS/DISABILITIES
❑	❑	HEPATITIS	❑	❑	ALLERGIES TO ANY DRUGS
❑	❑	TUBERCULOSIS	❑	❑	HISTORY OF SCARLET FEVER
❑	❑	HEART ATTACK	❑	❑	ARTIFICIAL VALVES
❑	❑	KIDNEY/LIVER PROBLEMS	❑	❑	HEART SURGERY/PACEMAKER
❑	❑	SHINGLES	❑	❑	MITRAL VALVE PROLAPSE
❑	❑	FEVER BLISTER	❑	❑	ARTIFICIAL BONES/JOINTS
❑	❑	VENEREAL DISEASE	❑	❑	SEVERE/FREQUENT HEADACHES
❑	❑	ULCERS/COLITIS	❑	❑	HI/LOW BLOOD PRESSURE
❑	❑	EMPHYSEMA	❑	❑	DRUG/ALCOHOL ABUSE
❑	❑	SINUS PROBLEMS	❑	❑	BLOOD TRANSFUSION
❑	❑	PROSTHESIS	❑	❑	ANEMIA/RADIATION TX
❑	❑	DIFFICULTY BREATHING	❑	❑	GLAUCOMA

OTHER: _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN	❑ YES ❑ NO	ERYTHROMYCIN	❑ YES ❑ NO
CODEINE	❑ YES ❑ NO	TETRACYCLINE	❑ YES ❑ NO
LATEX	❑ YES ❑ NO	OTHER: _____	
PENICILLIN	❑ YES ❑ NO	_____	

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE: _____ DATE: _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.