



FOR ADULTS: WELCOME TO OUR PRACTICE

Date: _____ OPMS#: _____

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

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: _____

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

HEART MURMUR

CANCER

DIABETES

RHEUMATIC FEVER

HIV+/AIDS

HEMOPHILIA

ASTHMA

HEPATITIS

TUBERCULOSIS

HEART ATTACK

KIDNEY/LIVER PROBLEMS

SHINGLES

FEVER BLISTER

VENEREAL DISEASE

ULCERS/COLITIS

EMPHYSEMA

SINUS PROBLEMS

PROSTHESIS

DIFFICULTY BREATHING

YES NO

CONGENITAL HEART DEFECT

CONVULSIONS/EPILEPSY

ABNORMAL BLEEDING

HEARING IMPAIRMENT

ANY OPERATIONS

ANY STAYS IN HOSPITAL

HANDICAPS/DISABILITIES

ALLERGIES TO ANY DRUGS

HISTORY OF SCARLET FEVER

ARTIFICIAL VALVES

HEART SURGERY/PACEMAKER

MITRAL VALVE PROLAPSE

ARTIFICIAL BONES/JOINTS

SEVERE/FREQUENT HEADACHES

HI/LOW BLOOD PRESSURE

DRUG/ALCOHOL ABUSE

BLOOD TRANSFUSION

ANEMIA/RADIATION TX

GLAUCOMA

OTHER: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPIRIN YES NO

CODEINE YES NO

LATEX YES NO

PENICILLIN YES NO

ERYTHROMYCIN YES NO

TETRACYCLINE YES NO

OTHER: _____

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: _____