

**For Office Use Only**

Date \_\_\_\_\_

Acct# _____
Records _____
Consult _____
Banding _____

# ADULT

## PATIENT INFORMATION

Patient's Name: _____	Nickname: _____
Street: _____	City: _____ Zip: _____
Sex: _____ Age: _____	Date of Birth: _____ Home Phone: _____
Patient's Dentist (first & last name): _____	Physician: _____
Referred by: _____	E-mail Address: _____
Sports: _____	Hobbies: _____
Reason for seeking treatment: _____	

## RESPONSIBLE PARTY INFORMATION

Patient's Occupation: _____	SS# _____	Work Phone: _____
Employer: _____	Address: _____	City: _____
How long with this employer: _____		
Spouse's Name: _____	SS# _____	Work Phone: _____
Spouse's Occupation: _____	How long with this employer: _____	
Spouse's Employer: _____	Address: _____	City: _____
Person responsible for account: _____	Phone: _____	
Responsible party's address: _____	City: _____	State: _____ Zip: _____
How long at this address: _____	Previous address (if less than 3 years): _____	
Do you have insurance which covers orthodontics: _____	Insurance company name: _____	
Name of Insured: _____	Group#: _____	Insured's Date of Birth: _____

**Check any of the following habits that apply to the patient:**

Habit	Now	Past	Stopped at age:
Mouth breathing: Awake ___ Asleep ___ Both ___			
Snoring:			
Clicking or pain in the jaw joint (by the ears):			
Grinding teeth: Awake ___ Asleep ___			
Sucking: Fingers ___ Thumb ___ Blanket ___			
Swallowing: Tongue Thrust ___			
Nail Biting			
Other:			
Current Medication Being Taken:			

**Does the patient have or has the patient had:**

Condition	Yes	No	?	Condition	Yes	No	?
Rheumatic Fever				Scarlet Fever			
Heart Condition				Whooping Cough			
Diabetes				Swallowing Problem			
Anemia				Breathing Problem			
Epilepsy				Chewing Problem			
Pneumonia				Nervous Condition			
Hepatitis				Glaucoma			
Type				Reaction to drugs			
Asthma				What?			
Tuberculosis/PPD(+)				Fainting			
Speech Problem				Kidney Problem			
Measles				Frequent Colds			
Chickenpox				Freq. ear infections			
Mumps				Other:			
Allergies							
To What?							

"I understand where appropriate, credit bureau reports may be obtained."

PATIENT SIGNATURE \_\_\_\_\_