ADULT PATIENT INFORMATION FORM

Welcome to our office… **DATE OF EXAM:** _____________
Please assist us by completing the following questions: **DATE OF BIRTH:** _____________

PATIENT'S NAME____
Last **First**

AGE__________ SEX________
ADDRESS________________________________CITY_______________POSTAL CODE_________
PHONE____________________ EMAIL________________________
PATIENT'S DENTIST________________________________
PATIENT'S PHYSICIAN ________________________________
NAMES OF OTHER MEMBERS OF YOUR FAMILY TREATED AT OUR OFFICE
____
PERSON RESPONSIBLE FOR ACCOUNT____
ADDRESS_______________________________________CITY________________POSTAL CODE__________
DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? YES☐ NO☐
PATIENTEMPLOYED BY____BUS PHONE_______________
SPOUSE'S NAME____OCCUPATION______________________

HOW WERE YOU REFERRED TO THIS OFFICE? (Dentist, family, friend, Yellow Pages, other)
____

MEDICAL HISTORY

Diabetes	☐	**Arthritis**	☐	**Gland Problems**	☐
Pneumonia	☐	**Anemia**	☐	**Prolonged Bleeding**	☐
Heart Trouble	☐	**Epilepsy**	☐	**Liver Involvement**	☐
Rheumatic Fever	☐	**Asthma**	☐	**Fainting and Dizziness**	☐
Bone Disorders	☐	**Kidney Involvement**	☐	**Nervous Disorder**	☐
AIDS/HIV	☐	**Hepatitis**	☐	**Sexually Transmitted Disease**	☐

	Yes	**No**
ARE YOU IN GOOD HEALTH?	☐	☐
ARE YOU UNDER A PHSYIAN'S OR CHIROPRACTOR'S CARE NOW?	☐	☐
DO YOU HAVE ANY DISEASE THAT CAN BE SPREAD BY CONTACT? (eg. HERPES)	☐	☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS: ______________________

LIST ANY ALLERGIES OR DRUG SENSITIVITY: ____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? ______ WHAT AGE? _______________________

IN THE LAST 24 HOURS HAVE YOU DEVELOPED A COUGH, SHORTNESS OF BREATH, FEVER OR CHILLS OR ONSET OF DIARRHEA? ______________________________________ ☐ ☐

DO YOU HAVE A NEW UNDIAGNOSED RASH, LESION, OR BREAK IN SKIN? ☐ ☐

HAVE YOU BEEN RECENTLY EXPOSED TO INFECTIOUS DISEASES? (eg. measles, chicken pox, tuberculosis)
______________________________ ☐ ☐

DO YOU HAVE A HISTORY OF JOINT PROSTHESES PROCEDURES IN THE PAST TWO YEARS?
____ ☐ ☐

DO YOU HAVE A HISTORY OF ANTIMICROBIAL THERAPY? ☐ ☐

IS THERE FAMILY HISTORY OF PRION DISEASE, OR SYMPTOMS THAT MAY BE INDICATIVE OF CJD, SUCH AS SUDDEN ONSET DIMENTIA? ☐ ☐

HAVE YOU RECENTLY TRAVELED TO AREAS WHERE ENDEMIC DISEASES ARE PRESENT?
____ ☐ ☐

DENTAL HISTORY

WHAT IS YOUR MAIN ORTHODONTIC CONCERN? ____
____

	Yes	No
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?	☐	☐
DO YOU HAVE ANY PROBLEMS WITH YOUR SPEECH? _______________________	☐	☐
DO YOU BREATH PREDOMINANTLY THROUGH YOUR MOUTH? __________________	☐	☐
DO YOU HAVE FREQUENT HEADACHES? ______________	☐	☐
HAVE YOU HAD ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS?	☐	☐
HAVE YOU BEEN INFORMED OF ANY MISSING PERMANENT TEETH? ___________	☐	☐
HAVE YOU HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? ________________	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH? ______________	☐	☐
HAVE YOU HAD ANY PERIODONTAL TREATMENT? _________________________	☐	☐
ARE YOU APPREHENSIVE ABOUT ORTHODONTIC TREATMENT? _________________	☐	☐
WHEN DID YOU LAST VISIT YOUR DENTIST? ______________________________	☐	☐
IS THERE ANY DENTAL TREATMENT STILL TO BE DONE? __________________	☐	☐
IS THERE ANOTHER FAMILY MEMBER WITH SIMILAR ORTHODONTIC PROBLEMS?____	☐	☐
WOULD YOU MIND WEARING BRACES? _____________________	☐	☐

LIST SPORTS, HOBBIES AND INTERESTS____

COMMENTS: ____
____

SIGNATURE______________________________