



Adult Patient Information

Today's Date _____

Patient's Name _____ I prefer to be called _____

Address _____ City _____ Zip _____

Email Address _____ Home Phone _____

Work Phone _____ Cell Phone _____ Best way to contact _____

SSN _____ D/O/B ____ / ____ / ____ Age _____ Sex _____

Employer _____ Occupation _____ How Long? _____

Spouse _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ How Long? _____

General Dentist _____ City _____ Last Visit _____

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

Marital Status _____ Person Responsible for this account _____

If different then above:

Billing Address _____ City _____ Zip _____

Email Address _____ Home Phone _____ Cell Phone _____

SSN _____ D/O/B ____ / ____ / ____ Age _____ Sex _____

Orthodontic Insurance Information

Primary Dental Insurance Orthodontic Coverage? Yes No

Insured's Name _____ Relation: _____ Employer _____

DOB ____ / ____ / ____ SSN _____

Insurance Company _____ Group No. _____ ID No. _____

Insurance Company Address _____ City _____ Zip _____

Insurance Company Phone _____

Do you have dual coverage? Yes No

Secondary Dental Insurance Orthodontic Coverage? Yes No

Insured's Name _____ Relation: _____ Employer _____

DOB ____ / ____ / ____ SSN _____

Insurance Company _____ Group No. _____ ID No. _____

Insurance Company Address _____ City _____ Zip _____

Insurance Company Phone _____

Emergency Information

Contact Person _____ Relation _____ Phone _____

Medical History

Physician's Name _____ Last Visit _____ Phone Number _____

Current physical condition Good Fair Poor

Are you currently under the care of a physician? Yes No

Have you ever been under the care of a physician for a major illness? Yes No _____

Please answer all questions by checking "Yes" or "No".

Good health Yes No

Recent illness Yes No

Recent cold, cough Yes No

Heart or chest pain Yes No

Heart murmur Yes No

High blood pressure Yes No

Rheumatic fever Yes No

Kidney disease Yes No

Lung disease Yes No

Diabetes Yes No

Hepatitis Yes No

Herpes (cold sores) Yes No

AIDS or HIV positive Yes No

Endocrine disorder Yes No

Growth disorder Yes No

Tonsils/Adenoids removed Yes No

Bleeding disorder Yes No

Prolonged bleeding Yes No

Leukemia Yes No

Sickle cell anemia Yes No

Anemia Yes No

Joint replacement Yes No

Asthma Yes No

Sinus problems Yes No

Hay fever, seasonal allergies Yes No

Nasal obstruction Yes No

Severe headaches Yes No

Bone disorder Yes No

Epilepsy Yes No

Canker sores Yes No

Antibiotics required for dental appointments Yes No

List any drugs (prescription and over the counter) that you are currently taking and please give reason _____

List any allergies or sensitivities including drug, latex, metal or other _____

Are you taking any medication for osteoporosis? If so, what and for how long? _____

Are you now, or could you be pregnant? Yes No If yes, how many weeks? _____

Dental History

What are the main concerns you would like orthodontics to accomplish? _____

Current dental health Good Fair Poor

Do you like your smile? Yes No

Have you ever been treated with orthodontics before? Yes No If yes, please explain: _____

Do you have any history of gum or periodontal disease? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had injuries to your face, mouth, teeth or chin? Yes No

Do you generally breath through your mouth? Awake: Yes No Asleep: Yes No

Do you have any missing or extra permanent teeth? Yes No If yes, please explain: _____

I have read and understand the above questions. I will not hold Dr. Newman or Dr. McNamara or any member of their staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature _____ Date _____