primeorthodontics
for children and adults

For Adult

Thank you for completing the information below.

The information in this history form will help us provide the best care and service

Patient Information - Adult

Patient's Name_____

First Middle Last

Nickname (if preferred)_____ Email_____

Age_____ Birthdate ____-____-____ M[ ] F[ ] F SS#_____-_____-_____

Home Address_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____

Married_____ Single_____ Widowed_____ Spouse Name_____

Person Responsible For Account

[ ]Same as above Name_____ DOB____-____-____ Relationship_____

Email_____ SS#_____-_____-_____

Billing Address_____ Home Phone_____-_____-_____ Work Phone_____-

_____-_____ Occupation_____Employer_____

Insurance Information

Dental Insurance Company Name_____

Insurance Phone_____-_____-_____ Insured's Name_____

DOB____-____-____ Insured's SS#_____-_____-_____ Relationship_____

Group Number_____ Policy Number_____

Employer and Address_____

_____

Medical History

Physician's Name_____ Phone_____-_____-_____

Yes No

[ ] [ ] Are you taking any pills, medications, or drugs?
[ ] [ ] Do you have any allergies or unusual reaction to any medications?

List Medications_____

Are there any medical problems you have and the doctor should be aware of?

_____

Dental History

Dentist's Name_____ Phone_____-_____-_____

What is the major concern about your teeth?_____

_____

Frequency of Dental Checkup/Cleaning_____

Date of Last Checkup/Cleaning____-____-____

Yes No

[ ] [ ] Have you had a previous orthodontic consultation of treatment?
[ ] [ ] Has any family member had orthodontic treatment? If so, Who?_____
[ ] [ ] Do you have pain or clicking of the jaw joint?
[ ] [ ] Do you grind or clench your teeth?
[ ] [ ] Do you ever have pains in the face or head?
[ ] [ ] Have you ever had severe jaw or head injury?
[ ] [ ] Do you snore?

Are there any other dental/orthodontic problems that the doctor should be aware of?

_____

How did you hear about us?_____

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

Patient Signature_____**Date**____-____-____