ADULT PATIENT FORM

CONFIDENTIAL INFORMATION

Last Name: .... First Name: .... Mr [ ] Mrs [ ] Miss [ ] Ms [ ] Dr [ ]

Consultation Date: .... Date of Birth: .... / .... / .... Age: .... Sex: ....

Address: .... City: .... Postal Code: .... Phone # ....

Referred by: .... Dentist: .... Physician: ....

PERSONAL INFORMATION

Person Responsible for account: .... Address (If different than above) : ....

....

Do you have Orthodontic Insurance? **[ ] YES [ ] NO**

Employed by: .... Occupation: .... Email: ....

Work Phone #.................................. Cell Phone # .... May we contact you there? **[ ] YES [ ] NO**

Name of other family members treated: ....

MEDICAL HISTORY (Indicate YES or NO)

Heart trouble	[ ] YES [ ] NO	Diabetes	[ ] YES [ ] NO	AIDS or HIV positive	[ ] YES [ ] NO
Rheumatic fever	[ ] YES [ ] NO	Epilepsy	[ ] YES [ ] NO	Hearing problems	[ ] YES [ ] NO
Hepatitis	[ ] YES [ ] NO	Pneumonia	[ ] YES [ ] NO	Ear aches	[ ] YES [ ] NO
Anaemia	[ ] YES [ ] NO	Prolonged bleeding	[ ] YES [ ] NO	Kidney problems	[ ] YES [ ] NO
Headaches	[ ] YES [ ] NO	Stomach trouble	[ ] YES [ ] NO	Fainting & dizziness	[ ] YES [ ] NO
Eye problems	[ ] YES [ ] NO	Asthma	[ ] YES [ ] NO	Nervous disorders	[ ] YES [ ] NO
Arthritis	[ ] YES [ ] NO	Cancer	[ ] YES [ ] NO		

Are you in good health **[ ] YES [ ] NO** List any medications being taken: ....

....

Is there any history of major illness **[ ] YES [ ] NO** List any allergies or drug sensitivities: ....

....

Do you have a tendency towards ....colds **[ ] YES [ ] NO** ....sore throats **[ ] YES [ ] NO** ....ear infections **[ ] YES [ ] NO**

Have tonsils and adenoids been removed **[ ] YES [ ] NO** Do you smoke **[ ] YES [ ] NO**

Are you pregnant or anticipating becoming pregnant **[ ] YES [ ] NO**

continued...

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DENTAL HISTORY (Indicate YES or NO)

Are you a mouth breather .... while awake [ ] YES [ ] NO

Are you a mouth breather .... while sleeping [ ] YES [ ] NO

Are you aware of .... grinding teeth [ ] YES [ ] NO

Are you aware of .... jaw joint noise [ ] YES [ ] NO

Are you aware of .... pain in ear region [ ] YES [ ] NO

Are there any missing or extra permanent teeth [ ] YES [ ] NO

Any injuries to the face, mouth or teeth [ ] YES [ ] NO

Do you have any speech problems [ ] YES [ ] NO

Have any teeth been extracted [ ] YES [ ] NO

Frequent colds or canker sores [ ] YES [ ] NO

Previously seen by an orthodontist [ ] YES [ ] NO

Do you want orthodontic treatment [ ] YES [ ] NO

Do you play any musical instruments................ [ ] YES [ ] NO

When did you last have a dental check-up ....

Do you play sports? Which ones ....

Reason for orthodontic consultation ....

....

....

Signature of Patient Signature of Orthodontist Date

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