



ADULT PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work/Cell phone _____

Previous Address (If less than 3 years) _____

Birthdate ____/____/____ Age _____ Sex: M _____ F _____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced__

Social Security _____ Email Address _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate ____/____/____ Work Phone _____

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

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

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

Signature _____ Date: _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have you ever smoked or chewed tobacco? _____
- Yes No Have seen a physician in the last 12 months? Why? _____
- Female Patients only:
- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have your wisdom teeth been removed? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth, or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No What is your attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- How did they feel about the result? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No Are you aware that some appointments will be during work hours? _____

BENEFITS

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Fillman to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform Dr. Fillman. I authorize my insurance company indicated on this form to pay Dr. Fillman all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions. I authorize Dr. Fillman to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance.

Signature: _____ Date: _____