ADULT FORM

Date: _____

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

Mailing Address: _____

How long at this address: _____ Email address: _____

Main Phone #: _____ *Cell Home Work* Second Phone #: _____ *Cell Home Work*

Marital Status: _____ If married, what is your spouse's name: _____

Dentist: _____ Date of Last Visit: _____

Occupation: _____ School/Employer: _____

Whom May We Thank for Referring You: _____

RESPONSIBLE PARTY INFORMATION *(Other than Patient)*

Primary Responsible Name: _____ Relationship to Patient: _____

Mailing Address: _____

How long at this address: _____ Email address: _____

Main Phone #: _____ *Cell Home Work* Second Phone #: _____ *Cell Home Work*

Date of Birth: _____ Social Security #: _____

Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____ How long: _____

Second Responsible Name: _____ Relationship to Patient: _____

Mailing Address: _____

How long at this address: _____ Email address: _____

Main Phone #: _____ *Cell Home Work* Second Phone #: _____ *Cell Home Work*

Date of Birth: _____ Social Security #: _____

Marital Status: _____ Spouse's Name: _____

Employer: _____ Occupation: _____ How long: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____ Phone Number: _____

Subscriber's Name _____ Relationship to Patient: _____

Employer: _____ Group #: _____

ID# or Social Security #: _____ Date of Birth: _____

Second Insurance Company: _____ Phone Number: _____

Subscriber's Name _____ Relationship to Patient: _____

Employer: _____ Group #: _____

ID# or Social Security #: _____ Date of Birth: _____

EMERGENCY CONTACT

Nearest Relative Not Living with You: _____

Phone Number: Cell: _____ Home: _____

Address: _____

MEDICAL HISTORY

Name of Physician _____ Phone # _____ Date of Last Exam _____
Address _____

Do you have a current Medical Problem? YES NO If YES, What? _____

Have You Ever Had Any of the Following?

Heart Attack/Stroke	YES	NO	Psychiatric/Learning Problems	YES	NO
High/Low Blood Pressure	YES	NO	Epilepsy/Seizures/Fainting Spells	YES	NO
Diabetes	YES	NO	Heart Murmur/Heart Disease	YES	NO
Rheumatic Fever	YES	NO	HIV+/Aids	YES	NO
Hemophilia/Abnormal Bleeding	YES	NO	Heart Surgery/Pacemaker	YES	NO
Cancer/Chemotherapy/Radiation	YES	NO	Mitral Valve Prolapse	YES	NO
Kidney Problems	YES	NO	Artificial Bones/Joints	YES	NO
Asthma	YES	NO	Sinus/Breathing Problems	YES	NO
Adenoids/Tonsils Removed	YES	NO	Hepatitis	YES	NO
Tuberculosis	YES	NO	Congenital Heart Disease	YES	NO
VD (Syphilis, Gonorrhea)	YES	NO	ADHD	YES	NO
Major Operations	YES	NO	Pain/Pressure/Tightness in Chest	YES	NO

List Any Other Medical Conditions _____

Please Check All That Apply

Pregnant	YES	NO	Premature Birth	YES	NO
On A Prescribed Diet	YES	NO	Using Dilatin or Equivalent	YES	NO
Using Thyroid Drugs	YES	NO	Using Hormones (Inc. Birth Control)	YES	NO
Using Anxiety Medications	YES	NO	Have you taken Bisphosphonate Drugs?	YES	NO
Disorder	YES	NO			

Genetic

List Any Other Medical Conditions _____

Are You Taking Medications For:

Diabetes	YES	NO	Blood (Liver, Iron, Pills)	YES	NO
Nerves (Tranquilizers/Relaxants)	YES	NO	Stomach Trouble	YES	NO
Sleeping	YES	NO	Headaches	YES	NO
Heart/Blood Pressure	YES	NO	Allergies	YES	NO

Are You Aware of Any Allergies:

Aspirin/Codeine	YES	NO	Penicillin/Tetracycline/Erythromycin	YES	NO
Sulfa Drugs	YES	NO	Other Antibiotics _____	YES	NO
Dental Anesthetic (Ex. Novocain)	YES	NO	Latex/Rubber Globes	YES	NO
Metal/Nickel Allergies	YES	NO	Other _____	YES	NO

DENTAL HISTORY

What is the main reason for seeking Orthodontic Treatment? _____

Have you had previous Orthodontic Treatment? If so, by whom? _____

Do you have missing permanent teeth? If so, List _____

Do you Pre-Medicate before a Dental Appointment?	YES	NO
Does you gums bleed when they are brushing?	YES	NO
Have you ever been told they have 'Gum Disease' or Periodontitis?	YES	NO
Have you ever had professional instructions on Dental Home Care?	YES	NO
Is any part of your mouth sensitive to temperature or pressure?	YES	NO
Does food catch between your teeth?	YES	NO
Do you have any soreness around your eyes or ears?	YES	NO
Do you have any unpleasant odor, or taste in your mouth?	YES	NO
Are you dissatisfied with the appearance of your teeth?	YES	NO
Are you currently experiencing any pain?	YES	NO
Have other family members had treatment in our office?	YES	NO

Do You Have Any of the Following?

Ringing in the Ears	YES	NO	Pain in Teeth	YES	NO
Neck Pain	YES	NO	Face Pain	YES	NO
Back Pain	YES	NO	Jaw Pain	YES	NO
Headaches	YES	NO	Grinding of Teeth	YES	NO
Dizziness	YES	NO	Popping/Clicking of Jaw Joint	YES	NO

Have You Ever Experienced the Following?

Been in an accident?	YES	NO	Explain _____
A blow to the jaw?	YES	NO	Explain _____
An injury to the mouth/teeth/chin?	YES	NO	Explain _____
Your jaw joint locked or felt like it was sticking?	YES	NO	Explain _____

Would you say your Dental Health is: POOR FAIR GOOD

By signing below, I certify that the information provided today is complete and accurate. I also understand that it is my responsibility to inform the office of any changes regarding my medical health. I authorize Bailey Orthodontics Staff to perform necessary dental services that I may need during diagnosis and treatment.

I hereby authorize my insurance benefits to be paid directly to Bailey Orthodontics Office and I authorize Bailey Orthodontics to release any information to process insurance claims.

Signature _____ Date _____