Welcome

Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU: Today's Date: _____

Name: _____
Last First Mi

Nickname: _____ ❑ Male ❑ Female
Birthdate: ___/___/___ Age: _____
School: _____ Grade: _____
College: _____ SS #: _____
E-mail Address: _____
Hobbies / Sports: _____

_____
Home Phone: (_____) _____
Home Address: _____

_____
City State Zip

Whom may we Thank for referring you? _____

_____
Previous / Present Dentist: _____
(Please Circle)

Last visit date: _____
Other family members seen by us with Birthdate:

Name	Birthdate
_____	___/___/___
_____	___/___/___
_____	___/___/___

Who is responsible for making appointments?

Name: _____ Relation: _____
Work Phone: (_____) _____
Home Phone: (_____) _____

Parent Information:

E-Maill Address: _____
Who is accompanying you today? _____
Name: _____ Relation: _____
Does this person have legal custody of you? ❑Yes ❑ No
Parent's Marital Status: (Please Circle)
Single Widowed Married Divorced Separated Partnered

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ___/___/___
Wk Phone:(___)_____ Hm Phone:(___)_____
Employer: _____ SS #: _____
How long at current job? _____ Job title: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ___/___/___
Wk Phone:(___)_____ Hm Phone:(___)_____
Employer: _____ SS #: _____
How long at current job? _____ Job title: _____

Person Responsible For Account:

Name: _____ Relation: _____
Employer: _____ DL #: _____
Wk Phone:(___)_____ Hm Phone:(___)_____
Social Security #: _____
Billing Address: _____

_____
City State Zip

Previous Address: _____

_____
City State Zip

Primary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/___ SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/___SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____

_____
City State Zip

CONTINUED ON BACK

Why have you come to the dentist today? _____

_____

Have you experienced problems with previous dental work? ❑ Yes ❑ No

Is your water fluoridated? ❑ Yes ❑ No

Are you taking fluoridated supplements? ❑ Yes ❑ No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Do you brush your teeth daily? ❑ Yes ❑ No

Floss your teeth daily? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

Do you require antibiotics before dental work? ❑ Yes ❑ No

Have you ever taken Phen-Fen? ❑ Yes ❑ No
Also known as Redux or Pondimin. If so, when? _____

Are you currently under a physician's care? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Please describe your current physical health:
❑ Good ❑ Fair ❑ Poor

Please list all drugs that you are currently taking: _____

_____

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No ❑ Unsure Week #: ___

Are you nursing? ❑ Yes ❑ No

For orthodontic treatment please complete the following:

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

_____

Have you ever been evaluated/had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to your face, mouth, teeth or chin? ❑ Yes ❑ No

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Do you still have your wisdom teeth? ❑ Yes ❑ No

Have you played any musical instruments? ❑ Yes ❑ No

If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin
Y N Any Metal / Jewelry
Y N Plastic
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other Allergies that you have _____

_____

DID/DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb / Finger Sucking
Y N Tongue Thrust
Y N Clenching / Grinding Teeth
Y N Lip Sucking / Biting
Y N Mouth Breather
Y N Nail Biting
Y N Were you breastfed?
Y N Used Pacifier

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal Bleeding
Y N Anemia
Y N Any Hospital Stays
Y N Artificial Bones / Joints
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV+ / AIDS
Y N Kidney Problems
Y N Liver Problems
Y N Lupus
Y N Measles
Y N Mononucleosis
Y N Mitral Valve Prolapse
Y N Rheumatic / Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are your Immunizations current? ❑ Yes ❑ No

Please discuss any serious medical problems you've experienced:

_____

_____

Is there anything you would like to discuss with the doctor in private? ❑ Yes ❑ No

I understand that I am responsible (If 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

_____
Patient Signature Date

_____
Parent/Guardian Signature (If Necessary) Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____
Signature of Patient and/or Parent/Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature of Patient and/or Parent/Guardian Date

The Patient or Parent/Guardian is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: ___/___/___
Doctor's Comments:

_____

_____

