Member
American Association of
Orthodontists

PATIENT INFORMATION-ADULT

Today's Date_____

Patient's Name _____
First Middle Last

Sex _____ Age _____ Date of Birth _____ Soc. Sec. #_____ _____ _____

Home Address _____
Street City State Zip Code

Home Phone # _____ Alternate #_____ ( ) cell ( ) work

Email_____ Employer_____ Occupation_____

How did you hear about our office? _____
*If a friend or family member referred you, please be sure to provide their name so we may thank them.

What would you like orthodontic treatment to accomplish? _____

_____

Insurance Information

1. Policy Holder's Name _____

Address_____

Phone #_____ Alternate # _____ Email _____

Date of Birth _____ Soc. Sec. # _____ _____ _____ Relationship to Patient _____

Employer _____ Occupation_____

1. Insurance Company _____ Group # _____

Telephone # of insurance company (_____) _____

2. Policy Holder's Name _____

Address_____

Phone # _____ Alternate #_____ Email _____

Date of Birth _____ Soc. Sec. # _____ _____ _____ Relationship to Patient _____

Employer_____ Occupation_____

2. Insurance Company _____ Group # _____

Telephone # of insurance company (_____) _____

Dental History

General Dentist Name_____ Address (City) _____

Date of last visit to the Dentist _____ Date of last X-rays taken _____

Has the patient had, or have you noticed any of the following: (Please check all that apply)

- ☐ Teeth sensitive to hot, cold, sweets or pressure
- ☐ Traumatic injury to teeth, mouth, or face
- ☐ Pain or tenderness around ear, jaw joint, or side of face
- ☐ Difficulty in: ☐ *Opening* ☐ *Closing* ☐ *Chewing*
- ☐ Clicking, locking, or popping of jaw joint
- ☐ Tonsils or adenoids removed
- ☐ Mouth breathing
- ☐ Oral habits: ☐ *Thumb sucking* ☐ *Fingernail biting* ☐ *Cheek biting*
- ☐ Clenching or grinding of teeth
- ☐ Loosening of your teeth
- ☐ Periodontal treatment
- ☐ Missing Teeth

If you answered *yes* to any of the above, please explain _____

_____

Has patient ever had any orthodontic treatment? ☐ Yes ☐ No When? _____

Medical History

Medical Physician _____/_____ Date of Last Medical Exam_____
Name City

List any Medications _____ List any **serious** illnesses_____

Is the patient in good health? ☐ Yes ☐ No

Is patient **allergic** to: ☐ Penicillin ☐ Codeine ☐ Local anesthetic injections ☐ **other** _____

Has the patient ever been diagnosed or treated for any of the following: PLEASE CHECK EACH INDIVIDUALLY

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	Heart Murmur	☐	☐	Emotional problems
☐	☐	Abnormal blood pressure	☐	☐	Asthma/breathing problems	☐	☐	Herpes
☐	☐	Bleeding problems	☐	☐	Fainting/Dizzy spells	☐	☐	Ulcers
☐	☐	Anemia	☐	☐	Frequent headaches	☐	☐	A.I.D.S.
☐	☐	Rheumatic fever	☐	☐	Epilepsy	☐	☐	H.I.V.
☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis or liver problems	☐	☐	Diabetes
☐	☐	Cancer or Leukemia	☐	☐	Tuberculosis or lung disease			

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I understand that credit bureau reports may be obtained. I read and understand English.

Signature of responsible party _____ Date _____

_____ _____
Dante A. Gonzales, D.M.D., M.S.D. Date