Patient Information / Adult

Patient Name: _____
First Last Middle

Birth Date: _____ Social Security #: _____ Gender: Male / Female

Address: _____
Street City State Zip

How long have you been at your current address? _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ # of Years Employed: _____

Spouse's Name: _____
First Last Middle

Spouse's Employer: _____ Occupation: _____ # of Years Employed: _____

Spouse's Birth Date: _____ Spouse's Social Security #: _____ Relationship to Patient: _____

Insurance Information

Insured's Name: _____ DOB: _____ Insured's SS #: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Co. Address: _____ Phone #: _____

Insured's Employer: _____

Do you have dual coverage? Yes No If yes, please continue:

Insured's Name: _____ DOB: _____ Insured's SS #: _____

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Co. Address: _____ Phone #: _____

Insured's Employer: _____

Emergency Information

Name of nearest relative not living with you: _____

Complete Address: _____
Street City State Zip

Phone #: _____ Relationship to Patient: _____

Signature: _____ **Date:** _____

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

Patient Health History — *West Loop Orthodontics*

Patient Name: _____ **Date:** _____

Name of Medical Doctor: _____ Date of Last Exam: _____

1. Are you under medical treatment now? Yes _____ No _____ If yes, please explain: _____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:

   _____
3. Are you taking any medication(s)? Yes _____ No _____ If yes please list:

   _____
4. Have you ever taken Phen-Fen/Redux? Yes ____ No ____
5. Do you use tobacco? Yes ____ No ____
6. Do you use controlled substances? Yes ____ No ____
7. Do you wear contact lenses? Yes ____ No ____
8. If you are allergic to or have had any reaction to any of the following, please circle:
   Local Anesthetics; Penicillin or other Antibiotics; Sulfa drugs; Barbiturates; Sedatives; Iodine; Aspirin; Metals; Latex or Rubber

   List any other allergies: _____
9. Do you have, or have you had any of the following: (if yes, please circle)

Heart Trouble	High Blood Pressure	Leukemia	Frequently Thirsty
Heart Disease	Low Blood Pressure	Cancer	Diabetes
Heart Attack	Respiratory Problems	Radiation Therapy	Swollen Ankles
Heart Murmur	Easily Winded	Rheumatic Fever	Joint Replacement / Implant
Mitral Valve Prolapse	Hay Fever	Tuberculosis	Arthritis
Cardiac Pacemaker	Asthma	Thyroid Problem	Stomach Troubles / Ulcers
Chest Pains	Emphysema	Weight Loss	Sexually Transmitted Disease
Stroke	Fatigue / Exhaustion	Liver Disease	AIDS or HIV
Angina	Fainting / Seizures	Kidney Disease	Depression / Psychiatric Care
Anemia	Epilepsy / Convulsions	Hepatitis / Jaundice	Glaucoma

   List any other medical issues: _____
10. Are you pregnant or breastfeeding? Yes ____ No ____

Name of General Dentist: _____ Date of Last Exam: _____

Does your Dentist have specific concerns about your teeth? _____

What would you like to see changed about your teeth and smile? _____

Have you ever broken or chipped a tooth? If yes, please explain: _____

If you have ever had any of the following habits, please circle: Finger or thumb sucking, chewing pens/pencils/other, biting fingernails

1. Do your gums bleed while brushing or flossing? ..... Yes ___ No ___
2. Are your teeth sensitive to hot or cold foods/fluids? ..... Yes ___ No ___
3. Are your teeth sensitive to sweet or sour liquids/foods? ..... Yes ___ No ___
4. Do you feel pain to any of your teeth? ..... Yes ___ No ___
5. Do you have any sores or lumps in or near your mouth? ..... Yes ___ No ___
6. Have you had any head, neck or jaw injuries? ..... Yes ___ No ___
7. Have you ever experienced any of the following problems in your jaw? (Circle all that apply) ..... Yes ___ No ___
   Clicking; pain (joint, ear, side of face); difficulty in opening or closing; or difficulty in chewing?
8. Do you have frequent headaches? ..... Yes ___ No ___
9. Do you clench or grind your teeth? ..... Yes ___ No ___
10. Do you bite your lips or cheeks frequently? ..... Yes ___ No ___
11. Have you ever had any extractions? ..... Yes ___ No ___
12. Have you ever had any prolonged bleeding following an extraction? ..... Yes ___ No ___
13. Have you ever had any orthodontic treatment? ..... Yes ___ No ___
14. Have you ever had periodontal (gum) treatment? ..... Yes ___ No ___
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ..... Yes ___ No ___
16. What aspect of orthodontic treatment is your main concern? Quality _____ Cost _____ Discomfort _____ Time _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such orthodontic care to third party payors and/or health practitioners.

X _____ Date: _____ X _____ Date: _____

Signature of patient (or parent/legal guardian) — Signature of additional parent/legal guardian

Patient Information / Child

Patient Name: _____
First Last Middle

Birth Date: _____ Social Security #: _____ Gender: Male / Female

School: _____ Grade: _____

Responsible Party Information

Name: _____
First Last Middle Marital Status

Address: _____
Street City State Zip

How long have you been at your current address? _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security #: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ # of Years Employed: _____

Spouse's Name: _____
First Last Middle

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X _____ Date: _____ X _____ Date: _____

Signature of patient (or parent/legal guardian) — Signature of additional parent/legal guardian