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ORTHODONTIC PATIENT INFORMATION - ADULT

A B C

PATIENT'S INFORMATION

First ________________________________ MI ____ Last __________________________________ Birth Date _______________

Residential Address ____ City ______________________ State _______ Zip ________

Mailing Address ____ City ______________________ State _______ Zip _______

How long at this address _______________ E-mail Address____

Previous Address (if less than 3 years) ________________________________ City ________________ State _______ Zip _______

Home Phone _________________________ Work Phone ________________________ Cell Phone __________________________

Social Security # ______________________________ Marital Status_____________

Employer ________________________________ Occupation ________________________ No. Years Employed ______________

Spouse's First Name _________________________ MI _____ Last ______________________________

Spouse's Employer _________________________ Occupation ________________________ No. Years Employed ______________

Spouse's Social Security # ___________________ Spouse's Birth Date _______________

RESPONSIBLE PARTY INFORMATION - *IF DIFFERENT THAN PATIENT*

First _______________________________ MI ____ Last ___________________________________ Birth Date _______________

Residential Address ____ City ______________________ State _______ Zip ________

Mailing Address ____ City ______________________ State _______ Zip _______

How long at this address _______ Home Phone ________________ Work Phone _______________ Cell Phone _______________

Previous Address (if less than 3 years) ________________________________ City ________________ State _______ Zip _______

Social Security # __________________________ Birth Date________________ Relationship to Patient _____________________

Employer ________________________________ Occupation ________________________ No. Years Employed ______________

Spouse's First Name ______________________ MI _____ Last ______________________Relationship to Patient ___________

Spouse's Employer _________________________ Occupation ________________________ No. Years Employed ______________

Spouse's Social Security # ___________________ Spouse's Birth Date _______________

INSURANCE INFORMATION - *Primary Insurance Information*

Insured's Name __________________________ DOB _____________ Insured's Social Security # ___________________________

Insurance Company ____Policy/ID# ____________________________________

Insurance Co. Address ____Ins Co. Phone______________________________

Employer____

Do you have dual coverage? ☐Yes ☐No If Yes,

Secondary Insurance Information

Insured's Name __________________________ DOB _____________ Insured's Social Security # ___________________________

Insurance Company ____ Group # _____________________________________

Insurance Co. Address ____ Ins Co. Phone_________________________________

Employer____

EMERGENCY INFORMATION

Name of nearest relative not living with you __________________________________Relationship to Patient__________________

Address ____Phone____

OTHER INFORMATION

Were you referred to this office ☐Yes ☐No Name of person referring you ______________________________

If you were not referred to this office, how did you hear about us? ☐Internet Ad ☐Website ☐Internet Search ☐Other ________

Has any member of your immediate family received treatment in our office? ☐Yes ☐No If so, Who? ________________

MEDICAL HISTORY

Physician's Name ________________________

Are you in good health? ☐Yes ☐No

Do you have or have you had any of the following diseases or problems?

☐ Rheumatic Fever
☐ Congenital heart problems
☐ Heart murmurs or heart surgeries
☐ Artificial heart valves
☐ Artificial joints
☐ Any condition that requires prophylaxis (antibiotics before dental procedures)
☐ Cardiovascular disease (heart attack, heart trouble, high blood pressure, stroke)
☐ Hepatitis - Type ________________
☐ Hemophilia
☐ Diabetes
☐ Epilepsy/Convulsions
☐ Asthma - controlled by ______________
☐ AIDS or HIV positive

List any other serious recurrent illnesses (physical or mental) ______________________________

Are you or have you ever taken bisphosphonate drugs (such as Boniva, Fosamax, Actonel, etc.) ☐ Yes ☐ No ☐ Oral ☐ IV

Allergic reactions? (Including latex) ____

DENTAL HISTORY

Dentist's Name ______________________________

Date of last cleaning/check-up ________________________

Have you had any of the following treatment?

☐ Periodontal treatment (gum treatment) How long ago? ________ Describe Treatment: ____________________
☐Mouth guard or splint - For what purpose? ____
☐ Surgery to change your bite

Are you aware of any of the following?

☐ Sores, lumps or irritated areas in your mouth
☐ Food catching between your teeth
☐ Clenching or grinding teeth
☐ Sore or bleeding gums
☐ Clicking, popping or grating noise in your jaw ☐Right ☐Left ☐Both sides
☐ Have you had your tonsils/adenoids removed?
☐ Have you been a thumb sucker? If yes, until what age? __________
☐ Have you been a mouth-breather?
☐ Have you been a lisper?
☐ Any unpleasant experiences at a dental office we should know about? If so, let us know.

The information I have given is correct and will be held in the strictest of confidence. I promise to be responsible for any charges that are incurred for the above-mentioned patient, and I authorize Dr. Devin P. Johnson, DMD, MS to evaluate and/or treat me.

I understand that where appropriate, soft-inquiry Credit Bureau reports may be obtained.

Signature of Responsible Party ______________________________ ***Date*** ______________________