Northern smiles orthodontics
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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 # _____ Birth Date _____
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 # _____ Marital Status _____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 _____ Group # _____
Insurance Co. Address _____
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 _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

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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* _____