Adult Patient Information

Name _____ Date of Birth _____ Age ____ Gender ____

Residence Address _____

Mailing Address (if different) _____

Phone: Home _____ Mobile _____ Other _____

E-mail Address _____

Employer _____ Occupation _____ Work Phone _____

Spouse's Name (if applicable) _____

Employer _____ Occupation _____ Work Phone _____

Whom may we thank for referring you to our office? ❑ General Dentist ❑ Friend ❑ Other _____

Responsible Party Information

Responsible Party (if other than self) _____ Relationship to patient _____

Mailing Address _____

Phone: Home _____ Mobile _____ Other _____

Social Security # _____ E-mail Address _____

Dental Insurance Information

Insured's Name. _____ Insured's Social Security# _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes _____ No _____ If yes: _____

Insured's Name _____ Insured's Social Security# _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone _____

Emergency Information

Name of emergency contact (not living with you) _____

Relationship to you _____ Phone(s) _____

Please complete BOTH sides of form.

Updates (Date & Initial) _____ _____ _____

Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident? _____

Female Patients only: Are you pregnant? Yes No

Please circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are you in excellent health? (Please circle) Yes / No

Any medical conditions that are not listed above: _____

Dental History

Dentist _____ Date of last visit _____

In your own words what is the problem? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth or teeth? _____

Yes No Is any part of your mouth sensitive to tempera~re or pressure? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you wake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you think that you might have sleep apnea? _____

Yes No Do you snore? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? Positive / Negative / Other _____

What is your attitude toward receiving orthodontic treatment? Excited / Nervous / Dreading it / Indifferent

Yes No Are you aware that some appointments will be during school / work hours?

Benefits

- Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth and in your general dental health. Teeth, gums and require specialized care provided by dental professionals. Porter Orthodontics provides orthodontic services only. Porter Orthodontics recommends that you see your general dentist at least every 6 months or more frequently as advised.
- I understand that my diagnostic records may be used for educational and professional purposes. Porter Orthodontics respects your privacy and will not use your records if you request.
- I have truthfully answered all the above questions and agree to inform this office of any medical or dental changes.
- I authorize Porter Orthodontics to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Print Name: _____

Updates (Date & Initial) _____ _____ _____