



Patient Information (Adults)

Last name _____ **First name** _____
Nickname or preferred name _____
Date of Birth (m/d/y) _____ **Sex:** Male Female
Age ____ **Weight** ____ **Height** ____ **Marital Status:** _____ **Spouse's Name:** _____

Residence:	Patient's Work Info:	Spouse's Work Info:
Address	Employer	Employer
City	Occupation	Occupation
Postal code	Number of Years Employed	Number of Years Employed
Home Phone	Work Phone	
Cell Phone	E-mail	
Email		
How long at this address?		

Your dentist's name _____ Your physician's name _____
 Who referred you to our office? _____ Emergency Contact Name _____
 Date of your last dental check-up _____ Emergency Contact Number _____

Dental Insurance Details: (if applicable)

Name of insurance company _____ Do you have orthodontic coverage: Yes No
 Name of policy holder _____ Relationship to patient _____
 Group number _____ Certificate number _____ Policy holder's S.I.N. _____
 Person responsible for account _____

Medical and Dental Information

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Under the care of a physician within the last 5 years? If yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of any serious illnesses? Please explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medications (vitamins, medicines or drugs including inhalers) at the present time?
If yes, which ones? _____ | | |
| 4. Have you ever had or been treated for (Please circle): | | |

- | | | | | | |
|-----------|-------------------|----------------|-------------------|-----------|-------------------|
| Cancer | Rheumatic fever | Blood pressure | Thyroid disorders | Anemia | A.I.D.S. |
| Asthma | Stomach disorders | Heart trouble | Eye trouble | Epilepsy | Other S.T.D.s |
| Sinusitis | Liver disease | Joint problems | Kidney disease | Hay fever | Osteoporosis |
| Diabetes | Blood disorders | Tuberculosis | Gall bladder | Hepatitis | Prosthetic Joints |

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 5. Do you have any allergies? If yes, to what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any adverse effects from any anesthetic, antibiotic or other medical drugs?
If yes, which ones? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have shortness of breath or difficulty breathing through your nose or mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had any radiation or X-ray therapy?
<input type="checkbox"/> | | <input type="checkbox"/> |
| 9. Do you get infections easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a heart murmur or heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get night sweats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you get frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has your jaw ever locked closed or open? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you grind or clench your teeth at night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you or have you ever had a history of thumb or finger sucking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a clicking or popping noise in your ear? Please specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

For our female patients:

- | | | |
|---|--------------------------|--------------------------|
| 17. Do you take birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you or do you suspect being currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

Date: _____ Signature: _____