primeorthodontics

For Adult

Thank you for completing the information below. The information in this history form will help us provide the best care and service.

Patient Information

Patient 's Name_____ Age_____DOB_____

First Middle Last

Nick Name (if preferred)_____ [ ] M [ ] F SS#_____

Home Address_____ Email_____

City_____ State_____ Zipcode_____

Home Phone_____ Cell Phone_____

Employer_____ Occupation_____

Employer's Address_____

Married_____ Single_____ Divorced_____ Widowed_____ Spouse Name_____

Person Responsible For Account

[ ] Same as above name_____ DOB_____ Relationship_____

Billing Address_____ City/State/Zipcode_____

Home Phone_____ Work Phone_____ SS#_____

Employer_____ Occupation_____

Employer's Address_____

Insurance Information

Primary Insurance Company Name_____ Phone Number_____

Group Number_____ Policy Number_____

Insured's Name_____DOB_____ Insured's SS#_____

Relationship_____ Insured's Employer_____

Employer's Address_____

Secondary Insurance Company Name_____ Phone Number_____

Group Number/Policy Number_____ Insured's Name_____ DOB_____

Insured's SS#_____ Relationship_____

Employer's Address_____

Medical History

Physician's Name_____ Phone Number_____Date of Last Visit_____

Address_____

Yes No

[ ] [ ] Are you taking any pills, medications, or drugs?

[ ] [ ] Do you have any allergies or unusual reaction to any medication?

List Medications_____

Are there any medical problems we should be aware of?_____

Dental History

Dentist's Name_____ Phone Number_____

Address_____

What is the major concern about your teeth?_____

Frequency of Dental Checkup/Cleaning_____ Date of Last Checkup/Cleaning_____

Yes No

[ ] [ ] Have you had a previous orthodontic consultation or treatment?

[ ] [ ] Has any family member had orthodontic treatment? Who?_____

[ ] [ ] Do you have any habits, such as thumb sucking, tongue thrusting, mouth breathing, nail biting?

[ ] [ ] Do you have pain or clicking of the jaw joint?

[ ] [ ] Do you grind or clench your teeth?

[ ] [ ] Do you ever have pains in the face or head?

[ ] [ ] Have you ever had severe jaw or head injury?

[ ] [ ] Do you snore?

Are there any other dental/orthodontic problems we should be aware of?_____

How did you hear about us?_____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status

I UNDERSTAND THAT WHEN APPROPRIATE CREDIT BUREAU MANY BE OBTAINED FOR FINANCIAL ARRANGEMENT.

Patient Signature_____ Date_____