Redd Orthodontics

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ADULT HISTORY

Today's Date: ________________

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below and bring it with you to your appointment.

Name: ____

SS #: __________________________

I prefer to be called: ___________________________ ______ Male ______ Female

Birthdate:___/_____/_____Age: ___________

Home Address: ____

Hm #: _________________ Wk #: _________________ Cell #: _________________ Email: __________________

___ Single ___ Married ___ Divorced ___Widowed ___Separated

Employer: ____ How long there? ______________________

Employer's Address: ____

Occupation: ____________________________________

Where & when are best times to reach you? ________________

Whom may we thank for referring you to our office? ____

Other family members seen by us: ____

General Dentist: ____ Last Visit Date: _______________

Spouse's Name: _________________________________

SS #: __________________________ Birthdate: ____________ Employer:__________________________

Wk #: ___________________ Ext: ________

Person Responsible for Account: ____________________________ SS # (if different from above): ______________

Billing Address: ____

Relation: __________________________ Wk #: _________________Ext: ______ Hm #: _____________________

Employer: ____

Orthodontic Insurance

Name & Address of Insurance Company: ____

Phone #: ________________________

Insurance Address: ____

Subscriber ID #: _____________________________________ Group #: ___________

Subscriber Name: ____________________________ SS #: ______________________ DOB: __________________

Employer Name: _________________________ Employer Phone #: __________________________

Employer Address: ____

Medical History

Do you have a personal physician? ___ Yes ___ No Date of Last Visit: ______________________
Physician Name: ______________________________ Phone #: _______________________________
Your current physical health is: __ Good __ Fair __ Poor
Are you currently under the care of a physician? __ Yes __ No
Please explain: ____
Are you taking any prescription / over-the-counter drug? __ Yes __ No
Please list each one:
____
____
Are you pregnant? __ Yes __ No Week #: _______
Have you ever had any of the following diseases or medical problems?

___Allergic to Latex / Metals	___Anemia	___Asthma	___Cancer / Chemotherapy
___Congenital Heart Defect	___Diabetes	___Difficulty Breathing	___Emphysema
___Epilepsy / Seizures	___Heart Attack	___ Stroke	___Fainting Spells
___Heart Murmur	___Heart Surgery	___ Pacemaker	___Hemophilia
___Abnormal Bleeding	___Hepatitis	___HIV + AIDS	___High / Low Blood Pressure
___Mitral Valve Prolapse	___Scarlet Fever	___Kidney Problems	
___Sinus Problems	___ Severe or Frequent Headaches		

Please list any serious medical condition(s) that you have ever had:
____
Please list any drugs that you are allergic to:
____
What are the main concerns that you would like orthodontics to accomplish?
____
____
Have you ever been evaluated for orthodontic treatment? ___ Yes ___ No
Have you ever had a serious/difficult problem associated with any previous dental work? __ Yes __No
Do you need Pre-medication prior to dental visits? ___ Yes ___ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ /TMD)?__Yes __No
Your current dental health is: __ Good __ Fair __Poor Do you like your smile? ___ Yes ___No
Do your gums bleed? __Yes __ No
Have you ever had an injury to your: Mouth ___ Teeth ___ Chin___
Do you smoke? __ Yes __ No
Do you have any speech problems? ____
Do you generally breathe through your mouth: __ Yes __ No Awake? __ Yes __ No Asleep? __ Yes __No
Do you have any missing or extra permanent teeth? __ Yes __ No

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
This office reserves the right to verify the credit status of potential patients and/or parents or patients prior to extending credit for treatment fees.
I authorize the orthodontic staff to perform any necessary orthodontic services that I may need during diagnosis and treatment with my informed consent.
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature:____ Date:_____________________________