Adult Orthodontic Record

PATIENT INFORMATION

Last Name ______________________ First Name ______________________
Nickname or Preferred Name ______________ Age ________ Birth Date ___ / ___ / _____ Sex: M [ ] F [ ]
Address ______________________ City ______________ State ______ Zip ______
Home Phone (____) _____ - ______ Work Phone (____) _____ - ______ Cell Phone (____) _____ - ______
Has any family member received treatment at our office? Yes [ ] No [ ] if yes, who? ______________
Dentist ______________ Whom may we thank for referring you? ______________

RESPONSIBLE PARTY INFORMATION

Same as above ☐

Last Name ______________ First Name ______________ Birth Date ___ / ___ / _____ Marital Status ________
Address ______________________ City ______________ State ______ Zip ______
Time at this address __________ Relationship to patient __________ Email ______________
Home Phone (____) _____ - ______ Work Phone (____) _____ - ______ Cell Phone (____) _____ - ______
Current Employer ______________________ Occupation ______________________
Spouse's Name ______________ Birth Date ___ / ___ / _____ Relationship to patient __________

ORTHODONTIC INSURANCE INFORMATION

Insurance Company (Primary) ______________
Address ______________
Phone Number (____) _____ - ______
Group Number ______________
Policy Holder Name ______________
Policy Holder Soc. Sec. No. ____ - ____ - ____
Policy Holder Birth Date ___ / ___ / _____
Policy Holder Employer ______________

Insurance Company (Secondary) ______________
Address ______________
Phone Number (____) _____ - ______
Group Number ______________
Policy Holder Name ______________
Policy Holder Soc. Sec. No. ____ - ____ - ____
Policy Holder Birth Date ___ / ___ / _____
Policy Holder Employer ______________

INITIAL EXAM INFORMATION

What is your chief concern in seeking orthodontic care? ______________________
What is your dentist's main concern regarding the patient's bite? ______________________
In an effort to avoid records duplication: has another orthodontist been consulted previously? Yes [ ] No [ ]

Our policy is that the adult who requests treatment is responsible for all fees for services rendered.

SIGNATURE ON FILE

By signing below:

- I authorize the use of this form and its information for all my insurance submissions.
- I authorize this office and its employees to act as my agent in helping me obtain insurance reimbursement.
- I authorize insurance payment directly to this office.
- I authorize the use of a copy of this form which can be used in place of the original.
- I understand where appropriate a credit report may be obtained.
- I understand where appropriate my credit card information may be obtained.

Signature ______________________________________ **Date** ___ / ___ / _____

SUNDANCE ORTHODONTICS

Adult Orthodontic Record

MEDICAL HISTORY

Please check yes or no for each condition (if yes, please explain)

Allergies

Yes [ ] No [ ] Acrylic
Yes [ ] No [ ] Aspirin
Yes [ ] No [ ] Ibuprofen
Yes [ ] No [ ] **Latex**
Yes [ ] No [ ] Metals
Yes [ ] No [ ] Nickel
Yes [ ] No [ ] Other ______________

Yes [ ] No [ ] Arthritis
Yes [ ] No [ ] Asthma
Yes [ ] No [ ] Attention Deficit Disorder

Blood disorders

Yes [ ] No [ ] Anemia
Yes [ ] No [ ] Bruise easily
Yes [ ] No [ ] Excessive bleeding
Yes [ ] No [ ] Other ______________

Blood pressure conditions

Yes [ ] No [ ] high
Yes [ ] No [ ] low

Yes [ ] No [ ] AIDS or HIV positive

Yes [ ] No [ ] Cancer
Yes [ ] No [ ] Chemo
Yes [ ] No [ ] Radiation

Cardiovascular conditions

Yes [ ] No [ ] Angina
Yes [ ] No [ ] Heart attack
Yes [ ] No [ ] Heart defect
Yes [ ] No [ ] Heart murmur
Yes [ ] No [ ] Stroke
Yes [ ] No [ ] Other ______________

Neurological disorders

Yes [ ] No [ ] Epilepsy
Yes [ ] No [ ] Fainting
Yes [ ] No [ ] Seizures
Yes [ ] No [ ] Other ______________

Yes [ ] No [ ] Headaches/migraines
Yes [ ] No [ ] Hepatitis
Yes [ ] No [ ] Kidney disorders

Do you have any other medical conditions that we should know about?

If yes, please explain:

____
____
____
____
____
____

MEDICATION HISTORY

Yes [ ] No [ ] Do you take any prescription medication, over the counter medication, nutritional supplements, or herbal medication?

Please list all medications...

Medication	Taken for

SUNDANCE ORTHODONTICS

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DENTAL HISTORY

Yes [ ] No [ ] Are your x-rays and fluoride treatments up to date?
Yes [ ] No [ ] Have you seen the dentist in the past six months?
Yes [ ] No [ ] Do you have missing teeth?
Yes [ ] No [ ] Do you have extra teeth?
Yes [ ] No [ ] Do you have slowly erupting teeth?
Yes [ ] No [ ] Do you have un-erupted teeth?
Yes [ ] No [ ] Do you have thin gum tissue?
Yes [ ] No [ ] Do you brush and floss regularly?

Is there anything else about your dental history that we should know about? ______________________________________
____
____
____

Now or in the past have you had...

Yes [ ] No [ ] ...any history of injured teeth?
Yes [ ] No [ ] ...injury to the head, neck, or jaws?
Yes [ ] No [ ] ...periodontal or "gum tissue" problems?

Jaw joint history

Yes [ ] No [ ] ...history of jaw joint pain?
Yes [ ] No [ ] ...history of jaw joint clicking or locking?
Yes [ ] No [ ] ...history of treatment for TMD or TMJ?

Functional/habit history

Yes [ ] No [ ] ...history of thumb or finger habit?
Until what age?______
Yes [ ] No [ ] ...history of tongue thrusting?
Yes [ ] No [ ] ...history of abnormal swallowing?

If yes to any above, please explain ____
____
____
____

Successful orthodontic treatment and beautiful smiles are achieved with a combination of appropriate diagnosis, excellent communication, and personalized attention. In an effort to specifically address your orthodontic concerns, please indicate what you would like orthodontics to accomplish for you:

[ ] Enhance aesthetics and appearance
[ ] Improve function, comfort, and stability
[ ] Enhance overall dental health
[ ] Create facial balance
[ ] Increase self confidence
[ ] Avoid further problems

I have read and understand the previous questions and I certify that the information I have provided is complete and accurate. In addition I acknowledge that I am solely responsible for any errors or omissions that may have been made in the completion of this four page form. As the responsible party I will immediately inform this office in the event of any change in medical and/or dental health status and will acknowledge change in status by signing and dating below.

Signature ________________________________ **On behalf of** __________________________ **Date** ____ /____/
(responsible party) (patient)