ADULT PATIENT INFORMATION

Date_________________

Patient's name____
Last First Middle

Mailing Address____
Street City Zip

Home phone____________________ Work phone_________________Cell Phone_______________________

Birthdate___________________________ Social Security#____

Email Address____ Marital Status__________________________

Employer____

Spouse's Name______________________________Spouse's employer________________________________

Social Security #______________________________Birthdate_____________Cell Phone_________________

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

DENTAL INSURANCE INFORMATION

Insured's Name__________________________________ Insured's Social Security #___________________

Insured's Birthdate______________________________

Insurance Company______________________ Group No._______________ Local No.________________

Insurance Co. Address____ Phone No._________________

Do you have dual coverage? Yes____ No____ If yes:

Insured's Name__________________________________ Insured's Social Security #__________________

Insurance Company______________________ Group No._______________ Local No.________________

Insurance Co. Address____ Phone No._________________

EMERGENCY INFORMATION

Name of nearest relative not living with you____

Phone______________________

MEDICAL HISTORY

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

Yes No Are you taking any medication? ______________________________
Yes No Do you have any allergies? ______________________________
Yes No History of a major illness? ______________________________
Female Patients only:
Yes No Are you pregnant?

Circle any of the medical conditions below that the patient has had or currently has.

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

Are there any medical conditions we have not discussed that you feel we should be aware of?____________

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DENTAL HISTORY

General Dentist______________________________Date of last visit ____________________

What concerns you most about your teeth?______________________________

____

Yes No Are you presently in any dental pain? ______________________________
Yes No Have there been any injuries to face, mouth, or teeth? ____________________
Yes No Is any part of your mouth sensitive to temperature? Where? ____________________
Yes No Is any part of your mouth sensitive to pressure? Where? ____________________
Yes No Any type of thumb or tongue habit? ______________________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ____________________
Yes No Good attitude toward receiving orthodontic treatment?____________________
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?______________
Yes No Experience jaw clicking or popping?______________________________
Yes No Aware of clenching or grinding teeth during the day?____________________
Yes No Have you ever experienced chronic ringing in the ears?____________________
Yes No Are you sensitive or self-conscious about your teeth? ____________________

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 general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Kunsemiller to perform a complete orthodontic evaluation.

Signature: ____ Date: ____________________