Adult Patient Information and Health Survey

Welcome to our office. Please fill out both sides of form.

Patient's Name _____ Age _____ Birth date _____ Sex ☐ M F ☐

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Business Phone _____

Occupation _____ Email _____

Marital Status _____

Social Security Number _____

Person responsible for financial matters

Name(s) _____

Address _____

City, State, Zipcode _____

Home Phone _____ Business Phone _____

Place of Employment _____

Social Security Number _____

	Family Dentist	Family Physician	Referred By
Name			
Address			
City, State			

Reason for orthodontic consultation? _____

Has anyone in your family had a similar problem? No ☐ Yes ☐

Are you self-conscious about your teeth? No ☐ Yes ☐

INSURANCE INFORMATION

Are you covered by insurance for orthodontic treatment? No ☐ Yes ☐

Insured Name _____ Insured Date of Birth _____

Insured Employer _____ Insured SSN# _____

Insurance Company _____ Insurance ID# _____

Insurance Verification Phone Number _____

Insured Claims Address _____

MEDICAL HISTORY – Has the patient ever had any of the following? (please circle)

☐ AIDS	☐ Bleeding	☐ Emotional Problems	☐ Hepatitis	☐ Previous Surgery
☐ Allergy	☐ Bone Loss/Disorders	☐ Epilepsy/Seizures	☐ Herpes	☐ Rheumatic Fever
☐ Anemia	☐ Cold Sores	☐ Hearing Problems	☐ Kidney Disease	☐ Thyroid Problems
☐ Arthritis	☐ Diabetes	☐ Heart Condition	☐ Lung Disease	☐ Other (describe below)
☐ Asthma	☐ Endocrine Problems	☐ Head or Face Injuries	☐ Oral Ulcer	

Comments _____

Has the patient been under the care of a physician during the past two years, other than for routine examinations?

No ☐ Yes ☐

Condition _____

Date of last medical exam _____

Do you require antibiotic premedication for dental procedures? No ☐ Yes ☐

Present drugs or medications _____

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Topeka, KS 66614
785-267-3855

Orthodontics for Families
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RESPIRATORY HISTORY

Do you:

- Have allergies to:

  Drugs: _____

  Food: _____

  Seasonal Grasses: _____

  Other: _____

- Breathe through mouth? Seldom☐ Sometimes☐ Usually☐
- Snore when sleeping? No☐ Yes☐
- Have frequent colds? No☐ Yes☐
- Have frequent "Stuffy Nose?" No☐ Yes☐
- Have frequent sore throat or tonsillitis? No☐ Yes☐
- Have difficulty chewing or swallowing? No☐ Yes☐

Have you received medical treatment from an allergist or ear, nose, and throat specialist? No☐ Yes☐

If yes: When _____ By Whom _____

Nasal Surgery☐ Tonsils removed☐ Adenoids removed☐

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Have you had any unusual dental experiences? No☐ Yes☐

Specify _____

Any injuries to the mouth, teeth or face? No☐ Yes☐

Specify _____

Date of last dental checkup _____ Were your teeth cleaned? No☐ Yes☐

Have you had an orthodontic consult or treatment? No☐ Yes☐

Do you have Headaches?☐ Neck Pain?☐ Jaw Pain?☐ Ear Pain?☐ Face Pain?☐ Eye Pain?☐ Other?☐

Which side hurts? Right?☐ Left?☐ Both?☐

If yes, please indicate when and where _____

_____

How long have you had these symptoms?

Years _____ Days _____ Months _____

Is the pain constant?☐ Aching?☐ Shooting?☐ Burning?☐ Stabbing?☐ Electrical?☐ Other?☐

Worse in the afternoon?☐ Worse in the morning?☐ Does it hurt to chew?☐ Does it hurt to open wide?☐

Does your jaw ever make a popping noise?☐ Clicking?☐ Grinding?☐ Other?☐

Has your jaw ever "locked" or slipped out of place? No☐ Yes☐

Do you ever clench or grind your teeth? No☐ Yes☐

During the day?☐ During the night?☐

Do you have problems with your ears?☐ Hearing?☐ Dizziness?☐ Other?☐

Is it difficult to swallow?☐ Painful?☐

Are the teeth sore or sensitive? No☐ Yes☐

Additional comments _____

_____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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