

Adult New Patient Form



ABOUT YOU

Name: _____
Last First MI

I prefer to be called: _____ Male/Female

Birthdate: _____ Age: _____

Home Phone: _____ Cell: _____

Home Address: _____

Email: _____

Single Married Divorced Widowed Separated

SS# _____

Employer: _____ # Years: _____

Employer's Address: _____

Occupation: _____

General Dentist: _____

Last Dental Visit: _____

How did you hear about our office?

Other family members seen by our office:

INSURANCE

Primary Dental Insurance:

Orthodontic Coverage? Yes/No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Group # (Plan, Local or Policy #): _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Birthdate: _____ SS#: _____

Policy Holder Employer: _____

Employer's Address: _____

Secondary Dental Insurance:

Orthodontic Coverage? Yes/No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone Number: _____

Group # (Plan, Local or Policy #): _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Birthdate: _____ SS#: _____

Policy Holder Employer: _____

Employer's Address: _____

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MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone Number: _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Please list any prescriptions or over the counter medications you are currently taking: _____

Do you smoke or use tobacco in any form? Yes No

Have you experienced the following medical problems?

- | | |
|-------------------------------|--------------------------------|
| Y N Abnormal Bleeding | Y N Alcohol/Drug Abuse |
| Y N Heart Murmur | Y N Syncope (Fainting) Spells |
| Y N AIDS/HIV+ | Y N Glaucoma |
| Y N Hospital Stays/Operations | Y N Sickle Cell Disease/Traits |
| Y N Hepatitis | Y N Kidney Disease |
| Y N Asthma | Y N Liver Disease |
| Y N Cancer | Y N Mitral Valve Prolapse |
| Y N Prosthetics | Y N Congenital Heart Defect |
| Y N Pacemaker | Y N Rheumatic/Scarlet Fever |
| Y N Diabetes | Y N Herpes/Cold Sores |
| Y N Epilepsy/Seizures | Y N Tuberculosis (TB) |
| Y N Artificial Joints/Valves | Y N High Blood Pressure |
| Y N Low Blood Pressure | Y N Emphysema |
| Y N Lupus | Y N Arthritis |
| Y N Anemia | Y N Heart Attack |
| Y N Blood Transfusion | Y N Colitis |
| Y N Sinus Problems | Y N Difficulty Breathing |
| Y N Stroke | Y N Psychiatric Problems |
| Y N Frequent Headaches | Y N Hay Fever |
| Y N Ulcers | Y N Thyroid Problems |

Are you allergic to any of the following?

- | | |
|-------------|-----------------------|
| Y N Latex | Y N Any metal/jewelry |
| Y N Plastic | |

Please list any other food or drug allergies that you have: _____

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

If yes, when are you due? _____

Are you nursing? Yes No

DENTAL HISTORY

What are the main concerns you would like Dr. Wing to address? _____

Have you ever been evaluated or had orthodontic treatment before? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Do you require antibiotics before dental work? Yes No

Have you ever had injury to your:

Mouth Teeth Chin

Do you have any speech problems? Yes No

Do you generally breathe through your mouth?

If yes: While Awake While Asleep

Do you still have your wisdom teeth? Yes No

Do you have any missing permanent teeth? Yes No

Do you have any extra permanent teeth? Yes No

Are you happy with the way your smile looks? Yes No

If not, what would you change? _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and this it is my responsibility to inform this office of any changes in my medical status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services I may need during diagnosis and treatment, with my informed consent.

Signature _____

Date _____

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I verbally reviewed the medical/dental information above with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____