PATIENT INFORMATION (ADULT)

Date____________________

Patient's name ____
Last First Middle

Age_______Birthdate:______________________Gender: M F Nickname/Preferred Name ______________________

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

Residence ____
Street City Zip

Mailing Address ____
Street City Zip

Home phone________________________ Work phone ____

Cell/other phone________________________ Email address ____

Employer_______________________________________ Occupation____

Spouse's Name__________________________________ Spouse's Phone_______________________________________

DENTAL INSURANCE INFORMATION

Insured's Name_______________________ D.O.B.___________Insured's Social Security # _________________________

Insurance Company__________________________ Group No.__________________ Employer______________________

Insurance Co. Address____ Phone No. _____________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_______________________ D.O.B___________ 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 ____

Complete address ____
Street City Zip

Phone ____

MEDICAL HISTORY

Physician ______________________________ Date of Last Visit ______________________
Address ______________________________ Phone ______________________

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

Yes	No	Are you taking any medication? **PLEASE LIST ALL MEDICATIONS**: ______________________
Yes	No	Are you allergic to any medication? **PLEASE LIST DRUG ALLERGIES:** ______________________
Yes	No	Do you have a history of a major illness? ______________________
Yes	No	Have you had any operations? ______________________
Yes	No	Have you ever smoked or chewed tobacco? ______________________
Yes	No	Have you ever been involved in a serious accident? ______________________
Yes	No	Have seen a physician in the last 12 months? Why? ______________________

Female Patients only:

Yes	No	Are you pregnant? **If so, # of weeks and due date:** ______________________

Circle any of the medical conditions below that you have had or currently have:

Allergy to latex or metals	Artificial Valves or Joints	Drug/Alcohol Abuse	Sexually Transmitted Disease
Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness/Vertigo	Herpes/Fever blister/Shingles	Radiation/Chemotherapy
Arthritis	Epilepsy/Seizures	High/Low Blood Pressure	Rheumatic Fever
Asthma/Hay Fever/Sinusitis	Gastrointestinal Disorders	HIV / AIDS	Thyroid Disease
Bone Disorders	Heart Problems/Stroke	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Mental/Behavioral Disorders	Tumor or Cancer
Hearing/Vision Problem	Migraine headaches	Apnea	Osteoporosis

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

DENTAL HISTORY

General Dentist ______________________________ Date of last visit ______________________

What concerns you most about your teeth? (eg, crowding, over/underbite, spacing, missing teeth, buck teeth, excessive wear)
____

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

Yes	No	Are you presently in any dental or jaw pain? ______________________
Yes	No	Have there been any injuries to the face, mouth, or teeth? ______________________
Yes	No	Have you ever been told that you are missing permanent teeth? ______________________
Yes	No	Do you have any teeth that are stuck in the jaw (impacted)? ______________________
Yes	No	Have you had your wisdom teeth removed? ______________________
Yes	No	Do you have any type of thumb- or finger-sucking habit? ______________________
Yes	No	Do you have a cleft lip and/or palate? ______________________
		If yes, date of alveolar bone graft (if applicable): ______________________
Yes	No	Have you ever seen an orthodontist? If yes, who and when? ______________________
Yes	No	Do your teeth or jaws ever feel uncomfortable? ______________________
Yes	No	Are you aware that some appointments will be during work hours? ______________________

Please list some hobbies or interests ____

PLEASE READ AND SIGN:

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. Dana M. Casaus to perform a complete orthodontic evaluation.

Signature: ____ Date: ______________________