



ADULT PATIENT INFORMATION

Patient's Name _____
I prefer to be called _____
Home Address _____
City _____ ST _____ Zip _____
How long at this address? _____
Home # () _____ Sex Male Female
Birth Date ____/____/____ Age _____
____ Single ____ Married ____ Divorced ____ Widowed ____ Separated
e-mail address _____
Employer _____
Address _____
City _____ ST _____ Zip _____
Occupation _____ # of years _____
Work # () _____ Extension _____
Where & when are the best times to reach you?

Whom may we thank for referring you?

General Dentist _____
Date of Last Visit _____

SPOUSE'S INFORMATION

Spouse's Name _____
Spouse's Employer _____
Occupation _____ WK # () _____
SS# _____ DOB ____/____/____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____
Billing Address _____
City _____ ST _____ Zip _____
Home # () _____ Work # () _____
Employer _____
SS# _____ DOB ____/____/____

PRIMARY ORTHODONTIC INSURANCE

Insurance Co Name _____
Address _____
City _____ ST _____ Zip _____
Phone # _____ Group# _____
Policy Holder's Name _____
SS# _____ DOB ____/____/____
Employer _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you

Address _____
City _____ ST _____ Zip _____
Home # () _____ Work # () _____
Relationship to Patient _____



MEDICAL HISTORY

Please describe your current physical health

Good Fair Poor

Are you currently under the care of a physician? Y N

Please explain _____

List any current prescription/over-the-counter drugs you are currently taking

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N week # _____

Are you nursing? Y N

Have you ever had any of the following diseases or medical problems?

- | | |
|-----------------------------|--------------------------------|
| Y N Abnormal Bleeding | Y N Hemophilia |
| Y N Anemia | Y N Hepatitis |
| Y N Artificial Bones/Joints | Y N High/Low Blood Pressure |
| Y N Asthma/Arthritis | Y N HIV Positive/AIDS |
| Y N Blood Transfusion | Y N Hospitalized/Reason |
| Y N Cancer/Chemotherapy | Y N Kidney Problems |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Psychiatric Problems |
| Y N Difficulty Breathing | Y N Radiation Treatment |
| Y N Drug/Alcohol Abuse | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizures | Y N Shingles |
| Y N Fever Blisters/Herpes | Y N Sickle Cell Disease/Traits |
| Y N Glaucoma | Y N Sinus Problems |
| Y N Heart Attack/Stroke | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers/Colitis |
| Y N Heart Surgery | Y N Venereal Disease |

Are you allergic to any of the following?

- | | |
|-------------------------|------------------|
| Y N Aspirin | Y N Erythromycin |
| Y N Any Metals/Plastics | Y N Latex |
| Y N Codeine | Y N Penicillin |
| Y N Dental Anesthetics | Y N Tetracycline |

Please list any other drugs/materials you are allergic to

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever seen an orthodontist? Yes ___ No ___

If so when? _____ Whom? _____

Have you ever had a serious/difficult problem associated with any previous dental work? _____

Do you like your smile? Y N Gums ever bleed? Y N

Have you ever had an injury to your Mouth/Teeth?

Do you have any speech problems? _____

Do you generally breath through your mouth? Y N

If yes, please circle: While Awake? While Asleep?

Any missing or extra permanent teeth? Y N

Have you ever taken Phen-Fen? Y N
(Also known as Redux or Pondimin)

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. This office reserves the right to verify the credit status of potential patients and/or responsible parties of patient prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. In addition, I authorize Dr. Valeriano and his dental staff to perform a complete orthodontic evaluation.

Signature Date

Our office is HIPAA compliant and the above signed has received a copy of our office HIPAA policies.

OFFICE USE ONLY OFFICE USE ONLY

Initials _____ Date _____

Doctor's comments: _____
