SeaBreeze ORTHODONTICS

ADULT PATIENT INFORMATION FORM

Welcome to our Office...

Please assist us by completing the following questions...

CONFIDENTIAL INFORMATION

Date_____

PATIENT INFORMATION

Last Name	First	Middle	Preferred Name		
Address					
City	State	Zip Code			
Home Phone	Date of Birth	Age	Sex: Male ☐ Female ☐	S.S.N.	
Employed by	Work Phone	Other			
Business Address	Occupation				
Favorite Sports, Hobbies & Avocations					
Children? Name(s)	Age(s)				
Spouse's name	S.S.N.				
Employed by	Work Phone	Other			
Business Address	Occupation				

RESPONSIBILITY PARTY INFORMATION

Name of Person Responsible for Account	Relationship to Patient	
Home Address *(If different from above)*	S.S.N.	
Employed by	Work Phone	Other
Business Address	Occupation	

INSURANCE INFORMATION

Primary Insurance Company	Name of Insured *Employee*	Policy Number
Secondary Insurance Company	Name of Insured *Employee*	Policy Number
In case we cannot reach you, person(s) to contact		Phone Number

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodonic treatment. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name:_____

Address:_____ Phone:_____

Are you in good health?	☐ Yes	☐ No	Explain:_____
Do you have a history of a major illness?	☐ Yes	☐ No	Explain:_____
Are you presently under the care of a physician?	☐ Yes	☐ No	Explain:_____
Are you presently taking any medications?	☐ Yes	☐ No	List:_____
Are you allergic or sensitive to any drugs, foods, and metals or other products (i.e. latex, nickel)?	☐ Yes	☐ No	List:_____
Have you had surgery that involves the placement of a prosthesis (i.e. hip/knee replacement, heart valve replacement)?	☐ Yes	☐ No	Describe:_____
Have you had surgery or radiation treatment for a tumor or growth in the head and neck area?	☐ Yes	☐ No	Describe:_____
If female, are you or might you be pregnant?	☐ Yes	☐ No	

Continued...please complete the reverse side

Please check if the patient has had any of the following conditions:

☐ HIV Positive/AIDS	☐ Tuberculosis	☐ Allergies	☐ Stomach Ulcers	☐ Endocrine Problems
☐ Hepatitis Type _____	☐ High/Low BP	☐ Asthma/Lung Disease	☐ Gastric Reflux	☐ Nervous Disorders
☐ Liver Disease/Jaundice	☐ Diabetes	☐ Cancer	☐ Polio	☐ Bone Disorders
☐ Rheumatic Fever	☐ Bleeding Problems	☐ Anemia	☐ Mononucleosis	☐ Facial Pain
☐ Rheumatic Heart Dis.	☐ Lung Disease	☐ Glaucoma	☐ Substance Abuse	☐ Bulimia
☐ Scarlet Fever	☐ Epilepsy/Seizures	☐ Degenerative Joints	☐ Migraine Headaches	☐ Anorexia Nervosa
☐ Heart Murmur	☐ Arthritis	☐ Thyroid Problems	☐ Emotional Problems	☐ Muscular Disorder
☐ Heart Trouble/Surgery	☐ Lupus/CT Disease	☐ Venereal Disease	☐ Stroke	☐ Fainting Spells
☐ Heart Valve Defects	☐ Kidney Disease	☐ Rheumatoid Arthritis	☐ Frequent Headaches	☐ Other _____

Comments:_____

_____

DENTAL HISTORY

Dentist's Name _____

Address:_____ Phone:_____

Please check any of the following conditions for which you have been diagnosed or treated:

☐ Facial/Teeth/Jaw Injury	☐ Tongue Thrust	☐ Dead Teeth/Root Canal	☐ Ringing in the Ears	☐ Mouth Breathing
☐ TMJ/TMD/Jaw Problems	☐ Bleeding Gums	☐ Tooth Sensitivity	☐ Cold Sores	☐ Impacted Teeth
☐ Grinding/Clenching Habit	☐ Receding	☐ Chipped or Broken Teeth	☐ Mouth Ulcers	☐ Receding Jaw
☐ Jaw Clicking/Popping	☐ Gum Disease	☐ Thumb or finger habit	☐ Jaw Cysts/Tumors	☐ Other_____
☐ Jaw Locking	☐ Lip Habit	☐ Facial Pain	☐ Missing Teeth	☐ Other_____

Comments:_____

_____

Which of the following are significant concerns?

☐ Crooked/Crowded Teeth	☐ Over Developed Jaw	☐ Missing Teeth
☐ Impacted Teeth	☐ Tooth Wear	☐ Protruding Teeth
☐ Spaced Teeth	☐ Extra Teeth	☐ Overbite
☐ Under Developed Jaw	☐ Wisdom Teeth	☐ Other_____

Have you had a prior orthodontic exam or prior orthodontic treatment? ☐ Yes ☐ No

Are you currently under a general dentist's care? ☐ Yes ☐ No

When was your last dental exam and cleaning? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

If so, please explain:_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____ _____

Signature of Parent or Guardian Date

CONSENT FOR DIAGNOSTIC RECORDS

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

_____ _____

Signature of Parent or Guardian Date

Who may we thank for your referral?_____