

# Welcome

## Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

**TELL US ABOUT YOU:** Today's Date: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Mi

Nickname: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

College: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_

City State Zip

Whom may we Thank for referring you? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_

(Please Circle) Last visit date: \_\_\_\_\_

Other family members seen by us with Birthdate:

Name Birthdate

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

**Who is responsible for making appointments?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

**Parent Information:**

Who is accompanying you today? \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Does this person have legal custody of you?  Yes  No

Parent's Marital Status: (Please Circle) Single Widowed

Married Remarried Divorced Separated

**Mother's Information:**  Step Mother  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Wk Phone:(\_\_\_\_) \_\_\_\_\_ Hm Phone:(\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

How long at current job? \_\_\_\_\_ Job title: \_\_\_\_\_

**Father's Information:**  Step Father  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Wk Phone:(\_\_\_\_) \_\_\_\_\_ Hm Phone:(\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

How long at current job? \_\_\_\_\_ Job title: \_\_\_\_\_

**Person Responsible For Account:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

Wk Phone:(\_\_\_\_) \_\_\_\_\_ Hm Phone:(\_\_\_\_) \_\_\_\_\_

Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip

Previous Address: \_\_\_\_\_

City State Zip

**Primary Dental Insurance:**

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Policy Owner: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

**Secondary Dental Insurance:**

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City State Zip

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Policy Owner: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

**Why have you come to the dentist today and/or What are the main concerns that you would like orthodontics to accomplish?**

\_\_\_\_\_

\_\_\_\_\_

Have you experienced problems with previous dental work?  Yes  No

Is your water fluoridated?  Yes  No

Are you taking fluoridated supplements?  Yes  No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)?  Yes  No

Do you brush your teeth daily?  Yes  No

Floss your teeth daily?  Yes  No

Do your gums bleed?  Yes  No

Do you need to be premedicated before dental work?  Yes  No

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

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Please describe your current physical health:  
 Good  Fair  Poor

Please list all drugs that you are currently taking: \_\_\_\_\_

Has puberty begun? (Boys)  Yes  No

Has your voice changed?  Yes  No

Date menstruation began? (Girls) \_\_\_\_\_

Are you taking birth control pills?  Yes  No

Are you pregnant?  Yes  No  Unsure Week #: \_\_\_\_\_

Are you nursing?  Yes  No

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

Have there been any injuries to your face, mouth, teeth or chin?  Yes  No

Have adenoids or tonsils been removed?  Yes  No

Have you been informed of any missing or extra permanent teeth?  Yes  No

Do you still have your wisdom teeth?  Yes  No

Have you played any musical instruments?  Yes  No

If so, what? \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

- Y N Aspirin
- Y N Any Metal
- Y N Plastic
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Other

Please list any other Allergies that you have \_\_\_\_\_

**DID/DO YOU HAVE ANY OF THE FOLLOWING HABITS?**

- Y N Nursing Bottle Habits
- Y N Speech Problems
- Y N Thumb / Finger Sucking
- Y N Tongue Thrust
- Y N Clenching / Grinding Teeth
- Y N Lip Sucking / Biting
- Y N Mouth Breather
- Y N Nail Biting
- Y N Were you breastfed?
- Y N Used Pacifier?

**HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?**

- Y N Abnormal Bleeding
- Y N Anemia
- Y N Any Hospital Stays
- Y N Asthma
- Y N Cancer
- Y N Chicken Pox
- Y N Congenital Heart Defect
- Y N Convulsions / Epilepsy
- Y N Diabetes
- Y N Exposed to HIV, but Neg.
- Y N Handicaps / Disabilities
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Hemophilia
- Y N Hepatitis
- Y N Hives
- Y N HIV+ / AIDS
- Y N Immunizations Current
- Y N Kidney Problems
- Y N Liver Problems
- Y N Measles
- Y N Mononucleosis
- Y N Mitral Valve Prolapse
- Y N Rheumatic / Scarlet Fever
- Y N Skin Rash
- Y N Tuberculosis (TB)

**Please discuss any serious medical problems you've experienced:**

\_\_\_\_\_

Is there anything you would like to discuss with the doctor in private?  Yes  No

I understand that I am responsible (If 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Parent/Guardian Signature (If Necessary) Date

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

**I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.**

**I authorize the dental staff to perform the necessary dental services I may need.**

\_\_\_\_\_  
Signature of Patient and/or Parent/Guardian Date

**The Patient or Parent/Guardian is responsible for payment at time of service unless prior arrangements have been approved.**

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_