Patient Information - Adult

Name: _____
Last First MI

I prefer to be called: _____

Male: _____ Female: _____ Birthdate: ___/___/___ Age: _____

□ Single □ Married □ Divorced □ Widowed □ Separated

Hobbies: _____

Home Phone #: __(____)_____

Cell Phone #: __(____)_____

Email address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

How long have you worked there? _____

Work phone #: __(____)_____ ext: _____

Where/when is the best time to reach you? _____

_____

Do you have dental insurance? □ Yes □ No

If yes,

Policy holders name: _____

Date of birth: ___/___/___

Employer: _____

ID# or SS#: _____ GRP#: _____

Name of insurance company: _____

Insurance company phone: _____

Policy holder's adderss: _____

Emergency/other contact information

His/Her name: _____

Relation: _____

Phone #: __(____)_____

Employer: _____

Work phone #: __(____)_____ ext: _____

Email address for appointment reminders:

_____

Would you also like appointment reminders via text messages? □ Yes □ No

If so, phone #: __(____)_____

What are your main concerns you would like orthodontics to address? _____

_____

Whom may we thank for referring you to our office?

_____

Other family member seen by us: _____

_____

General Dentist: _____

Date of last cleaning / exam: _____

Have you ever been evaluated for (or had) orthodontic treatment? □ Yes □ No

Have you ever had any injuries to your face, mouth, teeth, chin, or head? □ Yes □ No

If yes: _____

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

Have you ever had any teeth removed? □ Yes □ No

Have you had your tonsils and/or adenoids removed? □ Yes □ No

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

Your current dental health is: □ Good □ Fair □ Poor

Do you like your smile? □ Yes □ No

Do your gums ever bleed? □ Yes □ No

Are you currently experiencing any tooth pain or discomfort? □ Yes □ No

Do you wear a night guard/splint? □ Yes □ No

Do you now or have you ever experienced any symptoms related to your jaw joint (TMJ/TMD)? □ Yes □ No

If so, which of the following?

□ Clicking □ right □ left
□ Popping □ right □ left
□ Pain □ right □ left
□ Muscle soreness/tenderness □ right □ left
□ Locking open
□ Locking closed
□ Other: _____

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Fax: (651) 738-7928 Woodbury, MN 55125

www.hortonortho.com

Physician: _____

Physican's #: __(____)_____

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

If yes, for what condition? _____

Please list all medications you are currently taking:

_____

Please list all allergies (including drugs, foods, bee stings, etc.):

_____

_____

Have you ever taken bisphosphonate medication? □ Yes □ No

Please list all vitamins/supplements you are currently taking:

_____

Have you ever had any of the following habits?

Clenching	□ Yes	□ No
Grinding	□ Yes	□ No
Nail biting	□ Yes	□ No
Mouth breather	□ Yes	□ No
Lip-sucking/Biting	□ Yes	□ No
Tongue thrusting	□ Yes	□ No
Thumb/finger sucking	□ Yes	□ No
Soda pop drinker	□ Yes	□ No

Have you ever had any of the following?

Abnormal bleeding/blood disorder	□ Yes	□ No	Hemophilia	□ Yes	□ No
Allergies to any drugs	□ Yes	□ No	Hepatitis	□ Yes	□ No
Allergic to latex	□ Yes	□ No	High blood pressure	□ Yes	□ No
Allergic to metals	□ Yes	□ No	HIV +/AIDS	□ Yes	□ No
Anemia	□ Yes	□ No	Hospitalization	□ Yes	□ No
Arthritis/joint problems	□ Yes	□ No	Kidney or liver problems	□ Yes	□ No
Asthma	□ Yes	□ No	Mental health concerns	□ Yes	□ No
Bone disorders	□ Yes	□ No	Migraines	□ Yes	□ No
Cancer	□ Yes	□ No	Nerve or brain disease	□ Yes	□ No
Congenital heart defects	□ Yes	□ No	Operations	□ Yes	□ No
Diabetes	□ Yes	□ No	Pacemaker	□ Yes	□ No
Difficulty breathing	□ Yes	□ No	Psoriasis	□ Yes	□ No
Drug or alcohol abuse	□ Yes	□ No	Rheumatic/scarlet fever	□ Yes	□ No
Emphysema	□ Yes	□ No	Seasonal allergies	□ Yes	□ No
Epilepsy/Seizures/convulsions	□ Yes	□ No	Shingles	□ Yes	□ No
Fever blisters/herpes	□ Yes	□ No	Sinus infections	□ Yes	□ No
Glaucoma	□ Yes	□ No	Sleep apnea	□ Yes	□ No
Handicaps/disabilities	□ Yes	□ No	Swollen glands	□ Yes	□ No
Hearing impairment	□ Yes	□ No	Ulcers	□ Yes	□ No
Heart attack/stroke	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Heart murmur	□ Yes	□ No	Venereal diseases	□ Yes	□ No

Comments: _____

_____

Please list any other significant information about your medical history: _____

_____

_____

Have you ever needed to be premedicated for dental visits? _____

If so, please explain: _____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature of parent or guardian Date

Smile on.