



ORTHODONTIC ADULT PATIENT INFORMATION

Welcome to our office:

The following information is requested to enable me to give you the best consideration of your orthodontic problem during the initial examination. For me to thoroughly diagnose any condition, I must have accurate background and health information on which to base my decisions. This information, which is important for my records, is confidential. Thank You.

Patient's Name LAST FIRST MIDDLE Age Date of Birth / / Sex
Home Address STREET CITY ZIP How Long?
Employer: # Yrs. Employed? Occupation Work Phone
Home Phone Cell. Phone Social Security #: Marital Status:
Physician Dentist
Whom may we thank for referring you to our practice?
Husband/Wife Work #: Cell #:
Employer: Yrs. Employed? Social Security #:
Occupation: Person(s) Responsible for Account
Email Address:

Emergency Information

Name of Nearest Relative Not Living With You? Relation to Pt.:
Address: Telephone:

Medical History (Please Check Those That Apply)

- Arthritis Blood Disease Heart Disease Mononucleosis Thyroid Problems
Anemia Diabetes Hepatitis Nasal / Sinus Problems Tuberculosis
Asthma Epilepsy HIV Positive Rheumatic Fever Other: (describe below)
Back/Neck Pain Hearing Disorder Kidney Disease Speech Disorder

Comments:

Is antibiotic medication necessary before dental appointments due to a heart condition? Yes No
Have you been under the care of a physician during the past two years, other than for routine examinations? Yes No

Why?

Present drugs or medications:

Do you use any kind of tobacco? Yes No If yes, How much? per day, week or month

Do you have any emotional or psychological disturbances? If yes, briefly describe:

Female patients: Are you pregnant or could you possibly be pregnant? Yes No

Respiratory History

- 1. Do you have allergies to: Seasonal grasses Yes No Foods Yes No Metals Yes No Latex Yes No
Drugs Yes No Other:
If Yes, please specify:
2. Breathe through mouth regularly? Usually Sometimes Seldom
3. Snore when sleeping? Yes No
4. Have you received medical treatment from an allergist or ear, nose, and throat specialist? Yes No
If Yes, When? By Whom?
For What?
5. Do you have chewing or swallowing difficulty? Yes No

Dental History

Do you visit your dentist regularly (twice a year)? Yes No

When was your last visit to your dentist? _____ Were your teeth cleaned? Yes No

How many times do you brush your teeth daily? 1 2 3 More Floss Daily? Yes No

Facial or dental injury due to accidents or blows to the mouth? Yes No

If Yes, Explain: _____

Have you been informed of congenitally missing, extra, or impacted teeth? Yes No

Have you had any teeth extracted due to decay or gum disease? Yes No

Have you ever been treated by a periodontist (Gum Specialist)? Yes No

If yes, by whom? _____ When? _____

Do you clench or grind your teeth? Yes No

Do you have headaches frequently? Yes No

How often? _____ In the morning? Yes No In the evenings? Yes No

Other: _____

Location of headaches? _____

Have you ever experienced pain, clicking, or popping in your jaw joints? Yes No

Pain R L Clicking R L Popping R L Earaches R L

Has your jaw ever locked open? Yes No Locked Closed? Yes No

Have you ever been treated for temporomandibular joint (TMJ) problems? Yes No

If yes, by whom? _____ When? _____

Has an orthodontist been consulted previously? Yes No

Have you had orthodontic treatment previously? Yes No

By whom? _____ When? _____

Were you pleased with the results? Yes No

Has anyone in your family had orthodontic treatment? Yes No

Has there been any apprehension or unfavorable experience in a dental office? Yes No

Do you gag or faint easily? Yes No

What is the primary reason you are seeking this orthodontic evaluation?

What concerns do you have about braces, orthodontic treatment, etc.?

Please Read, Sign and Date: I, the undersigned, verify the accuracy of the above information. If there are any changes in the future, I will inform this practice of these changes. I hereby authorize Christopher M Feldman DDS LLC to obtain any information that may be required for credit acceptance in connection with the financial arrangements for orthodontic treatment.

Signature of Patient/Responsible Party

Date