CAMAS ORTHODONTICS

Date: _____

Adult Patient Information

Patient name: _____ _____ _____ _____ _____
Last First M.I. Preferred name (Preferred Pronoun)

DOB: _____ Social Security Number: _____ Marital status: ◯ Single ◯ Married ◯ Divorced

How did you hear about our office? _____

Cell phone: _____ Home phone: _____ Email: _____

Residence address: _____
Street City State Zip

◯ Rent ◯ Own No. of years at this address? _____ Previous address: _____
*if less than three years

Mailing address: _____
*if different from above

Employer: _____ Occupation: _____ No. years employed? _____

Spouse Information

(If applicable)

Spouse's name: _____ _____ _____ _____
Last First M.I. Preferred name

DOB: _____ Social Security Number: _____ Cell phone: _____

Residence Address: _____
*if different from above

Employer: _____ Occupation: _____ No. years employed? _____

Insurance Information

Policy holder's name: _____ DOB: _____ SSN: _____
Address (if different than above): _____
Insurance Co. name: _____ ID No. _____ Group No._____
Insurance Co. phone No. _____ Claims address: _____
Do you have dual coverage? If yes, please continue:
Policy holder's name: _____ DOB: _____ SSN: _____
Address (if different than above): _____
Insurance Co. name: _____ ID No. _____ Group No._____
Insurance Co. phone No. _____ Claims address: _____

Emergency Contact Information

Name: _____ **Phone:** _____ **Relationship to patient:** _____

SIGNATURE: **DATE**:

X

I understand that where appropriate, credit reports may be obtained.

Patient Medical History

Physician's name: _____ Approximate date of last physical exam: _____

Has the patient ever been under extended care of a physician? ◯ Yes ◯ No (if yes, please explain below):

_____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- ◯ Anemia
- ◯ Asthma
- ◯ Cold sores/Fever blisters
- ◯ Diabetes
- ◯ Depression
- ◯ Endocrine problems
- ◯ Excessive bleeding
- ◯ Heart problems
- ◯ Hepatitis
- ◯ HIV positive (AIDS)
- ◯ Nervous disorders
- ◯ Autism spectrum
- ◯ Pain in jaw joint(s)
- ◯ Rheumatic fever
- ◯ Anxiety
- ◯ ADD/ADHD
- ◯ Tuberculosis
- ◯ Other: _____

Does patient need to be medicated prior to dental appointments? ◯ Yes ◯ No (if yes, please explain):

_____

Does patient gag easily? ◯ Yes ◯ No

Does patient have special needs? ◯ Yes ◯ No (if yes, please explain):

_____

Does patient have frequent ear infections? ◯ Yes ◯ No

Have tonsils and adenoids been removed? ◯ Yes ◯ No

Women: Are you pregnant? ◯ Yes ◯ No

Are any medications currently being taken? ◯ Yes ◯ No (If yes, please list and explain):

_____

Does patient have any allergies? ◯ Yes ◯ No (if yes, please list):

_____

*foods, medications, environmental (i.e… hay fever)

PATIENT DENTAL HISTORY

General Dentist (name or name of office): _____ Approximate date of last cleaning: _____

Is there any dental work to be completed? (fillings, crowns, etc.) ◯ Yes ◯ No _____
Have there been any injuries to the face, mouth, or teeth? ◯ Yes ◯ No _____
Have you ever sucked your fingers or thumb? ◯ Yes ◯ No Until what age? _____
Does patient have any speech problems? ◯ Yes ◯ No _____
Have you ever had orthodontic treatment? ◯ Yes ◯ No _____
Have any family members had orthodontic treatment? ◯ Yes ◯ No _____
Are you a mouth breather? ◯ Yes ◯ No
Have you been informed of extra or missing permanent teeth? ◯ Yes ◯ No
Is there pain in the jaw? ◯ Yes ◯ No Right, Left, or Both? _____
Is there popping or clicking in the jaw joint(s)? ◯ Yes ◯ No Right, Left, or Both? _____
Does you clench or grind? ◯ Yes ◯ No
Does you regularly experience headaches? ◯ Yes ◯ No How often? _____

What is the chief concern that brought you to our office? _____