

ADULT PATIENT INFORMATION

Tell us about yourself

Patient's Name: _____ DOB: _____
_____ Age: _____
Preferred Name: _____ Male Female
Home #: _____ Cell#: _____
Email: _____
Occupation: _____
Hobbies/ Special Interests: _____
Whom may we thank for referring you? _____
General Dentist: _____
General Dentist #: _____
Date of last visit: _____
Marital Status Single Widowed Married Divorced

Spouse's Information

Name: _____
Work #: _____ Home# _____
Employer: _____
SS#: _____

Account Holder Information

Name: _____
Billing Address: _____

City State Zip
Work #: _____ Home # _____
Cell #: _____
Email: _____
Employer: _____

Primary Dental Insurance

Ins Name: _____
Ins Address: _____

Ins Co #: _____
Group/Policy # _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____ Insured's SSN: _____
Insured's Employer: _____

Secondary Dental Insurance

Ins Name: _____
Ins Address: _____

Ins Co #: _____
Group/Policy # _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____ Insured's SSN: _____
Insured's Employer: _____

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What are the main concerns you would like orthodontics to accomplish?

Has you been evaluated or had orthodontic treatment before?

Yes No- if yes, Who? _____

Have there been any injuries to the 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

Have you had any pain/tenderness in the jaw? Yes No

Do you brush your teeth twice daily? Yes No

Floss your teeth daily? Yes No

Please list any musical instruments you play:

Do you exhibit any of the following behaviors?

- YES NO
Nail Biting
Thumb Sucking
Teeth Grinding (Bruxism)
Open Mouth Breathing
Speech Impairment
Tongue Thrust (reverse swallow)

Medical History Updates:

Initial: _____ Date: _____

Initial: _____ Date: _____

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

Health History

- YES NO
Heart Disease
Cancer
Diabetes
Rheumatic Fever
HIV+/AIDS
Hemophilia
Asthma
Hepatitis
Tuberculosis
Arthritis
Congenital Heart Def.
Convulsions/Epilepsy
Abnormal Bleeding
Anemia
Endocrine/Thyroid
Hospital Stays
Kidney/Liver Problems
Handicaps/Disabilities
Allergies to Any Drug
Sleep Apnea

Please list any serious medical problems that you have had:

Do you normally pre-medicate before each dental visit?

Yes No

Do you take any bisphosphonate medications for bone disorders, such as Fosamax? Yes No

Please list and provide reasoning for any medications that are currently being taken:

Please list any allergies or drug sensitivity:

It is my understanding that the information I have given today is correct to the best of my knowledge. I am also aware that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I hereby authorize the staff at Buckhead Orthodontics to perform any necessary orthodontic services with my informed consent that I may need during diagnosis and treatment.

Signature: _____

Date:
Transfer Patients Only:
I hereby authorize the transfer of my orthodontic records to Michael B. Everson, DDS, MS.
Signature: _____
Date: _____