

Adult Orthodontic Form



Dietmeier
ORTHODONTICS
Creating Beautiful, Healthy Smiles

About You

Today's Date: ____/____/____

Name: _____
Last First MI

I prefer to be called: _____ Male Female

Birth date: ____/____/____ Age: ____

Home Address: _____
Apt/Condo#

City State Zip

How long at This Address? _____

Marital Status:
 Single Married Divorced Widowed

Home Phone Number: (_____) _____

Wk #: _____ DL# _____

Employer: _____

Employer's Address _____

How Long There? _____ Occupation _____

General Dentist: _____

Last visit date: _____

Other Family Members Seen By Us: _____

Whom may we thank for referring you?

Spouse Information

His/Her Name: _____

Employer: _____

Wk #: _____ Ext _____

Birthdate: _____ DL# _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

Home #: _____ Wk # _____

Medical History

Do you have a personal physician? Yes No

Physician's Name _____

Phone #: _____ Date of Last Visit _____

Your current physical health is Good Fair Poor

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

Please explain _____

Are you taking any prescription/over-the-counter drugs?
 Yes No

If yes, please list: _____

Are you allergic to any of the following items?

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Dental Anesthetics	<input type="checkbox"/> Any Metal/Plastic
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Other

Please list any other drugs that you are allergic to:

Have you ever had any of the following diseases or medical problems?

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Heart Surgery/Pacemaker
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Cancer/Chemotherapy	<input type="checkbox"/> Convulsions/Epilepsy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Abnormal Bleeding
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Any Operations?
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Any stays in a hospital?
<input type="checkbox"/> Asthma/Arthritis	<input type="checkbox"/> Kidney/Liver Problems
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Handicaps/Disabilities
<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Shingles
<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Drug/Alcohol Abuse	

Please discuss any medical condition(s) that you have had:

Do you need premedication for Dental Procedures?

Yes No

Dental History

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

Have you ever had or been evaluated for orthodontic treatment?

No Yes When? _____

Have you ever had a serious/difficult problem associated with any previous dental work?

No Yes When? _____

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? No Yes

Explain _____

Your current Dental Health is Good Fair Poor

Do you like your smile? No Yes

Do your gums ever bleed? No Yes

Have you ever had an injury to your: (Please Circle)

Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth?(Please Circle)

Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?

Yes No

I understand that the information that I have given today is correct to the best of my knowledge and this information 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 any necessary dental services that my child may need.

Signature _____ Date _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature _____ Date _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CENTER FOR DISEASE CONTROL AND THE AMERICAN DENTAL ASSOCIATION
