Dr. ________________

Recs. __________ ________
Date Time

X-Ray __________ ________
Date Time

Adult Form

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Orthodontic Specialists

www.straighttoothjunction.com

A B C

Report Date: ____________

EXAM

Month	Day	Year

1 | Tell us about yourself

Name ______________________________________ ______________________
Last First Middle Preferred Name

❑ Male ❑ Female Birth Date: ______________________ Age: __________

Address: ____ How long at this Address: __________
City Zip

Home Phone: (____) __________________ E-mail: ______________________________

Family in treatment with us: ____

____

Whom may we thank for referring you? ______________________________________

2 | General Dentist: ______________________ Last visit date: ______________

Address: ______________________________________ Phone #: (____) ______________

3 | Employer Information

Employer: ______________________________ Job Title: ______________________

Work Phone #: (____) ____________________ Fax or cell #: (____) ____________________

How long at current job: ____________ SS#: __________________ DL#: ______________

4 | Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Person (NOT living with you) to contact in case of emergency:

Name: __________________________ Relationship: __________ Phone #: (____) ____________

5 | Spouse Information

Name ___________________________________ Birth Date: ______________________

Employer: ________________ Work Phone #: (____) __________ Work Fax #: (____) __________

How long at current job: ____________ SS#: __________________ DL#: ______________

6 | Primary Orthodontic Insurance

Insurance Co. name: ____________________

Policy owner's name: ____________________

Policy owner's birthdate: ____________________

Policy owner's SS#: ____________________

7 | Secondary Orthodontic Insurance

Insurance Co. name: ____________________

Policy owner's name: ____________________

Policy owner's birthdate: ____________________

Policy owner's SS#: ____________________

8 | Dental History

Any injuries to head or mouth? ____________________ Any jaw clicking, locking or pain? ______________________________

Have you ever had orthodontic treatment? **Y** or **N** When: __________ Name of orthodontist: _________________________

Have your Wisdom Teeth been removed? **Y** or **N** When: __________ Name of oral surgeon: __________________________

What is your main concern? ____

Please check YES or NO to any of the following conditions that apply to you:

Y	N	(please check)	Y	N	(please check)	Y	N	(please check)
❑	❑	Bad Breath	❑	❑	Frequent Cold Sores, Canker Sores	❑	❑	Periodontal Problems / Pockets
❑	❑	Bleeding Gums	❑	❑	Grinding Teeth or Clenching	❑	❑	Root Canals
❑	❑	Chipped / Injured Teeth	❑	❑	Jaw Fractures	❑	❑	Sensitivity to Cold / Heat
❑	❑	Cyst / Infection	❑	❑	Loose Teeth or Broken Fillings	❑	❑	Teeth Irritating Cheek / Lips
❑	❑	Dental Treatment in Progress	❑	❑	Missing Teeth	❑	❑	Thumb Habit To Age _______
❑	❑	Difficulty Breathing / Chewing	❑	❑	Mouth Breathing	❑	❑	Tongue Habit, Swallowing Problems
❑	❑	Food Collection Between Teeth	❑	❑	Nail Biting	❑	❑	Any Permanent or Extra Teeth Removal

9 | Medical History

Physician ________________________________ Phone #: ____________________ Last visit: _______________

Please list all medications you are currently taking: ____

Are there any psychological or emotional problems that should be brought to our attention: ____________________

Do you need to be pre-medicated: **Y** or **N** Why: ______________________ Have you had joint replacement? __________

(Females) Are you: Taking birth control pills? **Y** or **N** Pregnant?: **Y** or **N** Nursing?: **Y** or **N**

Allergies: ____ Medical Insurance: ______________________________________
(Foods / Medications / Latex Gloves / Unknown ...)

Have you ever been hospitalized? **Y** or **N** Explain: ____

Please check YES or NO to any of the following conditions that apply to you:

Y	N	(please check)	Y	N	(please check)	Y	N	(please check)	Y	N	(please check)
❑	❑	Accidents	❑	❑	Chemotherapy	❑	❑	Hemophilia	❑	❑	Radiation Treatment
❑	❑	ADD / ADHD	❑	❑	Rehabilitation Drugs/Alcohol	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Disease
❑	❑	Anemia	❑	❑	Circulatory Problems	❑	❑	High or Low Blood Pressure	❑	❑	Rheumatic Fever
❑	❑	Arthritis, Rheumatism	❑	❑	Diabetes / Blood Sugar	❑	❑	HIV Positive / AIDS	❑	❑	Scarlet Fever
❑	❑	Artificial Heart Valves	❑	❑	Epilepsy	❑	❑	Jaw Pain	❑	❑	Severe Infections
❑	❑	Artificial Joints	❑	❑	Fainting-Seizures-Convulsions	❑	❑	Kidney or Bladder	❑	❑	Shortness of Breath
❑	❑	Asthma or Hay Fever	❑	❑	Glandular/Hormonal Problems	❑	❑	Liver Disease	❑	❑	Speech / Learning Disorder
❑	❑	Autism	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke
❑	❑	Back Problems	❑	❑	Headaches - Migraines	❑	❑	Mono	❑	❑	Thyroid Problems
❑	❑	Blood Disease	❑	❑	Hearing Loss	❑	❑	Nervous / Hyperactive	❑	❑	Tobacco Habit
❑	❑	Bruises Easily	❑	❑	Heart Murmur	❑	❑	Pacemaker	❑	❑	Tuberculosis
❑	❑	Cancer	❑	❑	Heart Problems	❑	❑	Pneumonia	❑	❑	Ulcer
❑	❑	Chemical Dependency	Describe:______________________			❑	❑	Prolonged Bleeding	❑	❑	Venereal Disease

10 | Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that, if necessary, credit bureau reports may be obtained.

It is my responsibility to advise the office of any changes in personal/medical status: Initials __________

Please sign that this information is accurate and complete:

Signature ____ Date ________________

Received by Dr. ____ Date ________________

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps or problems we might encounter? **Y** or **N**