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Date: ______________________________

Adult Patient Information

Full Name (Last, First, MI) ______________________________ Nickname ______________

Address (Street) ______________________________ City/State/Zip ______________

Social Security # ______________ Date of Birth ___/___/___ Present Age ________ Gender ________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Appointment reminders preference: ☐ Phone ☐ Email ☐ Text Email: ______________

Employer ______________ Occupation ______________ # of years ______

Whom may we thank for referring you to our office? ______________

Family Dentist ______________ Physician ______________

What would you like orthodontic treatment to accomplish? ______________

Has another orthodontist been consulted or previous orthodontic treatment been provided? ☐ Yes ☐ No

If yes, what work has been completed and by whom? ______________

Spouse Information

Spouse's Name: ______________________________ Marital Status ______________

Home Address ______________________________

Social Security # ______________ Date of Birth ___/___/___ Relationship to Patient ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________ Occupation ______________ No. Years Employed ______

Email address ______________________________

Appointment reminders preference: ☐ Phone ☐ Email ☐ Text Wireless Carrier ______________

Dental/Orthodontic Insurance

Orthodontic insurance coverage? ☐ Yes ☐ No ☐ Don't know **Dual Coverage?** ☐ Yes ☐ No

Primary Insured's Name ______________ Social Security # ______________ Date of Birth ___/___/___

Insurance Company ______________ Subscriber ID ______________ Group Number ______________

Secondary Insured's Name ______________ Social Security # ______________ Date of Birth ___/___/___

Insurance Company ______________ Subscriber ID ______________ Group Number ______________

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

Name of nearest relative not living with you ______________________________ Phone ______________

MEDICAL HEALTH HISTORY

In the following questions, circle yes or no whichever applies. Your answers are for our records only and will be considered confidential. **IF NECESSARY, *PLEASE EXPLAIN ALL POSITIVE RESPONSES BELOW.***

1. Are you under the care of a physician? . . . . Yes No
   If so, when was your last visit and the condition being treated?
   ____
2. Have you had any serious illnesses, accidents or operations? . . . . Yes No
   If so, please explain: ______________________________
3. Do you have or have you ever had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease? . . . . Yes No
   b. Congenital heart defects? Heart murmur? Heart disease? . . . . Yes No
   c. Artificial Heart Valve(s)? Artificial Joint(s)? . . . . Yes No
   d. Asthma or hayfever? . . . . Yes No
   e. Dizzy spells or seizures? . . . . Yes No
   f. Diabetes? . . . . Yes No
   g. Hepatitis, jaundice or liver disease?. . . . . Yes No
   h. Arthritis? Inflammatory rheumatism (painful, swollen joints)?. . . . . Yes No
   i. Kidney trouble? . . . . Yes No
   j. Tuberculosis? . . . . Yes No
   k. Thyroid problems? . . . . Yes No
   l. Venereal disease? AIDS or AIDS related disease? . . . . Yes No
   m. Frequent headaches? ☐ AM ☐ PM . . . . Yes No
   n. Do you currently use tobacco or have a past history of tobacco use? . . . . Yes No
   o. High or low blood pressure? . . . . Yes No
   p. Chronic ear pain or infections? . . . . Yes No
   q. Psychiatric counseling? . . . . Yes No
   r. Anemia? Bleeding Disorder?. . . . . Yes No
4. Have you had surgery or x-ray treatment of a tumor, growth or other condition of your head or neck? . . . . Yes No
5. Do you have any disease, condition or problem not listed above? . . . . Yes No
   If so, explain______________________________
6. Have your tonsils or adenoids been removed? . . . . Yes No
7. Are you taking any drugs or medicine? . . . . Yes No
   If so, what?______________________________
8. Are you allergic or have you reacted adversely to any medication?. . . . . Yes No
   If so, what?______________________________
9. Has a physician told you to take antibiotics before dental procedures? (pre-medication). . . . . Yes No
10. Are you able to breathe through your nose?. . . . . Yes No

FEMALES ONLY:

11. Are you pregnant?. . . . . Yes No
12. Have you started your menstrual cycle?. . . . . Yes No

Patient's known allergies:

Latex . . . . Yes No
Metal/Jewelry . . . . Yes No
Plastics . . . . Yes No
Anesthetics . . . . Yes No
Penicillin . . . . Yes No
Erythromycin . . . . Yes No
OTHER . . . . Yes No

Has the patient ever taken a **bisphosphonate medication** for a bone disorder or bone cancer such as: Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosto, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa . . . . Yes No

Comments: ______________________________

DENTAL HISTORY

1. Date of last dental cleaning: ______________________
2. Do you brush daily? ☐ Yes ☐ No How many times per day? ____________
3. How often do you floss? ______________________
4. Are you aware of any of the following conditions?
   a. Clenching or grinding your teeth? . . . . Yes No
      If so, does it occur during the: ☐ Day ☐ Night
   b. Any clicking, popping or locking of the jaw when opening or closing mouth? . . . . Yes No
      With pain? ☐ Yes ☐ No For how long?____________
   c. History of periodontal disease? . . . . Yes No
      If so, have you undergone any periodontal treatment or surgery? . . . . Yes No
   d. History of gingivitis (bleeding gums)? . . . . Yes No
   e. History of blisters on lips/mouth? . . . . Yes No
5. Have you ever had orthodontic treatment or been treated for a bad bite? . . . . Yes No
6. Any previous treatment for TMJ or jaw joint problems? . . . . Yes No
   If yes, explain: ______________________
7. Have you ever injured your face, jaw, mouth or teeth?. . . . . Yes No
8. Have any baby or permanent teeth been removed by your dentist? . . . . Yes No
9. Any known missing or extra permanent teeth? . . . . Yes No
10. Have you had wisdom teeth removed? . . . . Yes No
11. Any thumb, finger, or lip sucking habit? . . . . Yes No
    Is this habit: ☐ Active ☐ In the past Until what age? ____________
12. Has an orthodontist been consulted previously? . . . . Yes No
    If yes, reason: ______________________
13. Please list any family history of orthodontic treatment or jaw problems and name family relation:

    ____

    ____

14. Please list your main concern(s) and what you would like orthodontic treatment to accomplish:

    ____

    ____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information and have answered all questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to the patient's health. I authorize Clark Orthodontics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay direct to Clark Orthodontics including dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents. I authorize Clark Orthodontics to perform the necessary x-rays during initial and/or recall evaluations to assist in diagnosing proper treatment.

______________________ ______________________

Patient's signature (or parent or guardian if patient is a minor) Date