

Seuss Orthodontics

Life Changing Smiles

ADULT HEALTH FORM

PATIENT INFORMATION

Patient's name _____ Age _____ Sex: F [] M []
Birthdate ____/____/____ Marital status _____ SS/ID # _____
Home Address _____ Own [] Rent []
City, State _____ Zip _____ How long at address _____
Previous Address (if less than 3 years) _____
Home phone _____ Work phone _____ Cell phone _____
Employer _____ Occupation _____ No. years employed _____
Previous employer (if less than 3 years) _____ No. years employed _____
General Dentist _____ Physician _____
Spouse's Name _____
Employer _____ Occupation _____ No. years employed _____
Social Security # _____ Birthdate ____/____/____ Cell phone _____
Who may we thank for referring you to our office? _____

E-Mail address _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ DOB _____ SS/ID # _____

Signature of Insured for Assignment of Benefits _____

Employer _____ Relationship to patient _____

Insurance Company _____ Phone # _____

Address _____ Group # _____

Do you have dual coverage? **YES** **NO**

Insured's Name _____ DOB _____ SS/ID # _____

Signature of Insured for Assignment of Benefits _____

Employer _____ Relationship to patient _____

Insurance Company _____ Phone # _____

Address _____ Group # _____

EMERGENCY INFORMATION

Name of nearest **relative not living with you** _____ (relationship) _____

Address _____ Home phone _____

City, State _____ Zip _____ Work phone _____

I understand the information I have given is correct, I authorize the dental team to perform the necessary dental services I may need. I understand where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____

Patient's name _____

MEDICAL INFORMATION

Please check box if patient has or had any of the following:

- | | | | | | |
|--------------------------------|--------------------------|----------------------------|--------------------------|-----------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Endocrine/Thyroid Problem | <input type="checkbox"/> | Latex Allergy | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Liver/Kidney Problem | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Fever Blisters/Herpes | <input type="checkbox"/> | Nervous/Hyperactive | <input type="checkbox"/> |
| Blood Transfusion | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | Prolonged Bleeding | <input type="checkbox"/> |
| Bone Disorder | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Handicaps/Disabilities | <input type="checkbox"/> | Tobacco Use | <input type="checkbox"/> |
| Convulsions | <input type="checkbox"/> | Hearing Problems | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Emotional Problems | <input type="checkbox"/> | Heart Problems | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| Artificial Bones/Joints/Valves | <input type="checkbox"/> | HIV (tested positive)/Aids | <input type="checkbox"/> | Removal of Tonsils/Adenoids | <input type="checkbox"/> |
| | | | | History of Drug Use | <input type="checkbox"/> |

Is patient in good health? YES [] NO []

Is patient under physician's care? YES [] NO []

If so, for what reason _____

Are there any impending medical conditions? YES [] NO []

If so, describe _____

Is patient taking prescription medications? YES [] NO []

If so, list _____

For Females only:

Is patient pregnant? YES [] NO []

Does the patient take birth control pills? YES [] NO []

DENTAL HISTORY

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Has patient had a recent dental check-up? | <input type="checkbox"/> | <input type="checkbox"/> | Date _____ | | |
| Any missing teeth? | <input type="checkbox"/> | <input type="checkbox"/> | Any extra teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any night time clenching or grinding habit? | <input type="checkbox"/> | <input type="checkbox"/> | Clicking or pain when opening jaws? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any speech problems? | <input type="checkbox"/> | <input type="checkbox"/> | Surgery to repair cleft lip and/or cleft palate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent mouth breathing?(awake/sleeping) | <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever seen an orthodontist? | <input type="checkbox"/> | <input type="checkbox"/> |

Have any primary/permanent teeth been removed by extraction? YES [] NO []

Would patient mind wearing braces? YES [] NO []

Has a dentist ever placed a retainer or space maintainer? YES [] NO []

Do you understand some appointments will need to be scheduled during work/school hours? YES [] NO []

How many soft drinks consumed daily _____ weekly _____

How many sport drinks consumed daily _____ weekly _____

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

