WARD
ORTHODONTICS

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Adult Patient Information

Please answer all questions and bring the completed form to the Initial Exam

Patient's Name: _____Age:____ Birthdate: _____Sex:___
(Last) (First) (Initial)
Home Phone: _____ Cell # _____ Cell Provider _____
E-Mail_____
Address: _____City:_____ Zip: _____
Referred By: _____ General Dentist: _____
Names and ages of other children in the family: _____
_____ Physician: _____
Person Responsible for account: _____Relationship to patient: _____
Address (if different): _____Home Phone: _____
_____
Employed by: _____ Business Phone: _____
Birthdate: _____ Social Security #: _____
Name of Dental Ins. Co.: _____Dental Ins. Phone #: _____
Dental Ins. Address: _____
Group # _____ ID # _____
If there is additional dental insurance, please complete this section
Name of Employee: _____ Relation to patient: _____
Address (if different) _____ Home Phone: _____
_____
Employed by: _____Business Phone: _____
Birthdate: _____Social Security #:_____
Name of Dental Ins. Co.: _____ Dental Ins. Phone #:_____
Dental Ins. Address: _____
Group #_____ ID#_____

MEDICAL HISTORY:	YES	NO
Is the patient in good health?	___	___
Has the patient had any serious illness, accident, or operations?	___	___
If so, please describe: _____		
Is the patient presently under the care of a physician?	___	___
If so, what condition is being treated? _____		

Check any of the following conditions for which the patient has been treated or has experienced:

___Rheumatic Fever	___Liver Involvement	___Tuberculosis
___Heart Murmur	___Sinus Trouble	___Kidney Problems
___Congenital Heart disease	___Asthma or Hay Fever	___Endocrine Problems
___Diabetes	___Fainting Spells/Seizures	___Prolonged Bleeding
___Allergies	___Epilepsy	___Bone Disorders
___Sleep Apnea	___Snoring	

Does the patient have frequent:

___Colds ___Sore Throats ___Ear Infections ___Cold Sores ___Headaches

	YES	NO
Have tonsils or adenoids been removed?	___	___
If so, at what age? _____		
List any drugs or medications taken regularly, and for what conditions are they taken? _____		
Is the patient allergic to, or has the patient had any bad reactions to any medications?	___	___
Has the patient received counseling or treatment for drug or alcohol abuse?	___	___
Does the patient have any physical, mental, or emotional conditions which		

DENTAL HISTORY: YES NO

What was the date of the patient's last dental exam? _____		
Does the patient require premedication for dental procedures?	___	___
Has there been any injury to the face, mouth, or teeth?	___	___
If so, please describe: _____		
Have you been informed of any missing or extra teeth?	___	___
Have any teeth been removed early?	___	___
Does the patient have trouble chewing?	___	___
Is the patient a mouth breather…… while awake?	___	___
…….while asleep?	___	___
Has another orthodontist been previously consulted?	___	___
If so, doctor's name: _____ Date: _____		

Date: _____ Signature: _____

Please use this space for any additional information which you feel may be beneficial:

_____

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