ADULT PATIENT INFORMATION

DATE________________

Patient's Name ____ Date of Birth__________
First M. Last

Name you prefer to be called ________________________________ Age ________ Sex __________________

Mailing Address____
Street City State Zip Code

Home Phone____ Email Address_________________________

Cell Phone ____

Marital Status Married Single Divorced Widowed Social Security Number _______________________________

Names and ages of children in family: ____

Occupation_____________________________________ Employer ___________________________________

Employer phone _________________________________

Name of Spouse ________________________________ Social Security Number _________________________

Date of Birth ______________________________________ Employer ___________________________________

Employer Phone _____________________________________

Name of person responsible for account if other than yourself ____

Patient's Dentist__________________________________ Date of last visit to dentist________________

Any dental treatment pending? ____

Whom may we thank for referring you?____

Have any members of your family been patients in our office? Yes/No ______________________________________
Name(s)

Nearest Relative not living with You ____
Name Relationship Phone

MEDICAL HISTORY

Patient's Physician ____

List any medicines you are currently taking ____

List any drug sensitivity or allergies (including nickel) ____

Is there a history of serious illness, accident, or operation? ____

Please circle the following as they apply

Hepatitis	Bone Disorders	Frequent Sore Throats	Bleeding problems	Diabetes
AIDS/HIV	Tonsils/adenoids removed	Speech problems	Heart problems	Tuberculosis
Epilepsy	Rheumatic fever	Ear Infections/tubes	Mouth breathingADD/ADHD	
Arthritis	Kidney disease	Emotional problems	Hearing problems	

Other ____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? ____

Do you clench or grind teeth? Yes/No Do you have jaw joint soreness or pain? Yes/No

Have you ever had gum disease? ____

Has an orthodontist been consulted previously?_______________________________________

Have you had any previous orthodontic treatment?____

Primary reason for seeking orthodontic treatment____

Are there aspects of your facial appearance you would like to change? Describe:

____

Please list any additional information which you feel might be helpful

____

____

I certify that the above information is correct to the best of my knowledge. I authorize Dr. Dover to take x-rays and/or photographs as needed for diagnostic purposes.

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Patient's signature