BUENA VISTA ORTHODONTICS
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Adult Patient Information

Please fill out this form and bring to your first appointment.
Thank you for choosing us for your orthodontic care!

Patient First Name **Middle** **Last**

Today's Date:____/____/____ I prefer to be called _____ ☐ Male ☐ Female Birthdate: ____/____/_____ Age:_____

Address: _____ Apt. # _____ City_____ State_____ Zip_____

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Main phone to call_____ Ext._____
Home Cell Other non-work number

Email: _____ Best way to reach me: □ Phone □ Email □ Text □ All □ Other_____

Who may we thank for referring you to our office? (List all names if more than one)_____

What is your main concern in seeking an orthodontic consultation?_____

Dentist:_____ City_____ Phone_____ Yrs with DDS ____ Date of last visit_____

Physician:_____ City_____ Phone_____ Needs:_____

Other Medical or Dental Specialists seen? _____ Hobbies/Interests_____

Occupation: _____ Employed by: _____ Work Phone: (____) ____ - _____

Work Address:_____ Suite_____ City_____ State_____ Zip_____

Marital Status: □ Single □ Divorced □Married Spouse First Name:_____ Middle_____ Last_____

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Email: _____
Home Cell Other

Occupation: _____ Employed by: _____ Work Phone: (____) ____ - _____

Work Address: _____ I give my permission to discuss my treatment with my spouse _____initial

INSURANCE: Fill out all information and bring your insurance card.

Dental Insurance? □ No □Yes Provider: _____ Benefit: _____ Group #: _____ Subscriber #: _____

Orthodontic Coverage? □No □Yes Maximum: $_____ Any benefits used to date?_____

Other Dental Insurance? □ No □Yes Benefit_____ Other Orthodontic Insurance? □ No □Yes Benefit_____

Insured's name_____ Relation to you_____ Provider: _____ Group #: _____ Subscriber #: _____

Medical Insurance:_____ Flex plan? □ No □Yes Describe_____

FINANCIAL RESPONSIBILITY ☐ Patient (□ See info above) ☐ Spouse (□ See info above) ☐ Other (List information below)

Name: _____ Relationship to you: _____ Email_____

Address: (□ Same as patient) _____ City _____ State_____ Zip _____

Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____ Best #/Time_____

Birthdate: ____/____/_____ SSN: _____ - _____ - _____ Driver's License #: _____ State_____

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

ADDITIONAL EMERGENCY CONTACT: Name_____ Relation to you_____

Address: _____ City_____ State_____ Zip_____

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Email: _____
Home Cell Phone Work

Last Revised: 06/13/2010

MEDICAL HISTORY

Please answer the following questions with Yes or No to indicate if you have a history of any of the conditions listed. If you checked Yes, please describe the specific condition and check the appropriate boxes. Let us know if you have questions. Thanks.

Current medical treatment or needs? ☐ No ☐ Yes

_____

_____

Good health, appetite, energy level? ☐ No ☐ Yes

Explain if no:

_____

_____

Medications or drugs being taken now? ☐ No ☐ Yes

_____

_____

Need premedications for dental procedures? ☐ No ☐ Yes

- ☐ Antibiotics for heart murmur/ valve
- ☐ Blood clotting aids
- ☐ _____

Problems with the Immune System? ☐ No ☐ Yes

- ☐ Frequent infections
- ☐ AIDS ☐ Exposure to AIDS
- ☐ HIV+
- ☐ _____

Liver, Kidney, Genito-urinary problems? ☐ No ☐ Yes

- ☐ Hepatitis: ☐A ☐B
- ☐ Jaundice ☐ Venereal Disease
- ☐ _____

Surgeries, Hospitalizations? ☐ No ☐ Yes

_____

_____

Skin disorders or sensitivities ☐ No ☐ Yes

- ☐ Rashes/Hives/Allergies

_____

_____

Illnesses, Diseases? ☐ No ☐ Yes

- ☐ Diabetes ☐ Cancer
- ☐ Tuberculosis ☐ Polio
- ☐ Rheumatic/Scarlet Fever
- ☐ _____

Injuries? ☐ No ☐ Yes

- ☐ To face or jaws
- ☐ Broken bones
- ☐ Car accident
- ☐ _____

Drug reactions? ☐ No ☐ Yes

_____

_____

Allergies? ☐ No ☐ Yes

_____

_____

Heart, Circulation? ☐ No ☐ Yes

- ☐ Heart murmur/Valve problem
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack ☐ Heart surgery
- ☐ Stroke ☐ Angina or chest pains
- ☐ Needs to take medication regularly
- ☐ _____

Blood? ☐ No ☐ Yes

- ☐ Hemophilia ☐ Anemia
- ☐ Bleeds easily/excessively
- ☐ Bruises easily
- ☐ _____

Blood Sugar? ☐ No ☐ Yes

- ☐ Low blood sugar/hypoglycemic
- ☐ High blood sugar/hyperglycemic
- ☐ Diabetic
- ☐ Needs Medication

Lungs, Breathing? ☐ No ☐ Yes

- ☐ Asthma ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Sleep apnea/abnormal snoring
- ☐ _____

Digestion system? ☐ No ☐ Yes

- ☐ Ulcers
- ☐ Appendix removed
- ☐ Nervous stomach
- ☐ _____

Bones, Joints? ☐ No ☐ Yes

- ☐ Break easily
- ☐ Osteoporosis
- ☐ Arthritis: ☐ Rheumatoid
- ☐ Joint Pain
- ☐ _____

Sensory/Motor? ☐ No ☐ Yes

- ☐ Vision ☐ Hearing
- ☐ Taste/Smell ☐ Speech
- ☐ Coordination ☐ Hyper gag reflex
- ☐ _____

Neurological? ☐ No ☐ Yes

- ☐ Fainting ☐ Dizziness
- ☐ Epilepsy ☐ Convulsions
- ☐ Numbness/tingling
- ☐ _____

Pain? ☐ No ☐ Yes

- ☐ Face ☐ Body
- ☐ Headaches ☐ Neck
- ☐ Back ☐ Jaw
- ☐ Muscles ☐ Limbs
- ☐ _____

Psychological? ☐ No ☐ Yes

- ☐ Frequent anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Psychiatric disorder
- ☐ _____

Nose, sinus? ☐ No ☐ Yes

- ☐ Frequent congestion
- ☐ Frequently needs to breath through mouth
- ☐ _____

Females: Are you pregnant or plan on becoming pregnant during the course of treatment? ☐ No ☐ Yes

Names and ages of children?

_____

_____

DENTAL HISTORY

Current dental needs? ☐ No ☐ Yes

_____

_____

_____

History of injury to teeth? ☐ No ☐ Yes

_____

_____

- ☐ Trauma
- ☐ Fracture
- ☐ Root Canals

Oral diseases? ☐ No ☐ Yes

- ☐ Frequent sores on lip, mouth or gums
- ☐ Herpes
- ☐ _____

Problem teeth? ☐ No ☐ Yes

_____

_____

- ☐ Sensitive or aching teeth to: ☐ cold ☐ hot ☐ pressure

Gum or periodontal problems? ☐ No ☐ Yes

_____

_____

Have you ever had gum "pocket depths" measured? Result: ☐ No ☐ Yes

- ☐ Normal ☐ Deep pockets:

_____

Jaw or TMJ problems? ☐ No ☐ Yes

- ☐ Click/pop ☐ Soreness
- ☐ Stiffness ☐ Locking
- ☐ Headaches ☐ Face/muscle aches
- ☐ Previous treatment
- ☐ History of trauma or accident
- ☐ Sore jaws in morning
- ☐ Limited movement
- ☐ _____

Describe right jaw:

_____

Describe left jaw:

_____

Missing or extra teeth? ☐ No ☐ Yes

_____

Oral or Jaw surgery? ☐ No ☐ Yes

Teeth removed:

_____

Habits? ☐ No ☐ Yes

- ☐ Finger or lip habit ☐ Cheek biting
- ☐ Bites foreign objects
- ☐ Abnormal swallowing
- ☐ Abnormal tongue thrust
- ☐ Chews ice
- ☐ Grinding/clenching teeth during day
- ☐ Night grinding/bruxing
- ☐ Snoring
- ☐ _____

Previous Orthodontics? ☐ No ☐ Yes

Treatment:

_____

_____

Year:_____ ☐ Consultation Only

Are there any omissions in the medical or dental history? ☐ No ☐ Yes

Please list below and/or provide clarifications to any of the above questions.

_____

_____

Realizing that successful treatment greatly depends upon complete cooperation following instructions, keeping appointments, maintaining oral hygiene and regular visits to your dentist, are there any restrictions, handicaps or problems that might be encountered during treatment? Describe: ☐ No ☐ Yes

_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____

Patient's Signature

Date