ADULT INFORMATION SHEET

Name: ______________________ Preferred name: ___________________ Gender M F

Address: ____________________ Dentist: ______________ Physician: _____________

____________________ Birthdate______Phone # H_________ Cell_________

Occupation____________________ Employer__________________ Phone #__________

Email address: ________________________

Are you in good health? _________ Are you pregnant? _____

Do you require antibiotics for dental procedures? _____ Drug & dose __________________

How many cigarettes do you smoke per day? _____ Alcoholic drinks per day? ________

List medications taken regularly ____

List allergies (drugs, metals, latex, plastic, etc.) ________________________________

Describe any trauma to your face, teeth, or jaws _____________________________________

Do you have pain in your jaw? ______ Does your jaw pop or grate when you open? ______

Do you grind or clench your teeth? _____ Are you nervous in a dental office? _____

Please circle any conditions you have had and give details below:

Bleeding disorder	Blood transfusion	Bone/joint disease
Cancer	Depression/Anxiety	Diabetes
Heart murmer/defect	Hepatitis	High blood pressure
Headaches	HIV/AIDS	Hospitalizations
Kidney/liver disease	Seizures	Surgery

Details: ____

____

How often do you brush your teeth? _________ Floss? ________ Last x-rays _________

Describe any previous orthodontia: ____

What is your reason for seeking treatment now? ___________________________________

Whom may we thank for referring you to our office today? ___________________________

If you have orthodontic insurance, please fill out the reverse side of this form.

Signature _______________________ Date _________