WELCOME TO
MARTIN ORTHODONTICS

ADULT PATIENT INFORMATION

Patient's Name: _____ Nickname: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Best # to reach you: (_____) _____

Email Address: _____

Birthdate: _____ Age: _____ SS #: _____

Employer: _____ Wk #: _____

Occupation / Job Title: _____

Patient's Dentist: _____ Did they refer you to this office? ❑ Yes ❑ No

Do you know a patient in our practice? If so, whom: _____

Is there someone other than your dentist we may thank for referring you to us? Yes ❑ No ❑ (very important to us)

Is so, whom? _____

Who noticed your orthodontic problem? ❑ Patient ❑ Dentist ❑ Other _____

Describe your orthodontic problem in your own words: _____

What concerns you most about the thought of orthodontic treatment?

❑ appearance in appliances ❑ cost ❑ length of time ❑ discomfort ❑ results ❑ other _____

Interests or Hobbies: _____

Spouse's Name: _____ Employer: _____ Wk #: _____

Do you have any children? ❑ Yes ❑ No

Children's names and ages: _____

Person responsible for account: _____

Person to be notified in case of emergency: _____

INSURANCE INFORMATION

Are you covered by orthodontic insurance? ❑ Yes ❑ No

Name of Insured: _____ SS #: _____ DOB: _____

Name of Insurance Company: _____

Insurance Claims Address: _____

Insurance Telephone Number: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ Date: _____

Please fill out back

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address _____ Phone_____

Have you experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in your health recently? ☐ No ☐ Yes Explain: _____
Are you currently under physician's care? ☐ No ☐ Yes Explain: _____
Are you currently taking medications? ☐ No ☐ Yes List: _____
Do you require pre-medication for any dental procedure? ☐ No ☐ Yes List: _____
Are you allergic to any medications? ☐ No ☐ Yes List: _____
Have you received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Have you been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if you have had any of the following conditions:

Heart Murmur	☐ NO	☐ YES	Hepatitis	☐ NO	☐ YES	Emotional Problems	☐ NO	☐ YES
Heart Surgery	☐ NO	☐ YES	Diabetes	☐ NO	☐ YES	Frequent Headaches	☐ NO	☐ YES
Rheumatic Fever	☐ NO	☐ YES	Kidney Disease	☐ NO	☐ YES	Nervous/Anxious	☐ NO	☐ YES
Endocrine Disorders	☐ NO	☐ YES	Liver Disease	☐ NO	☐ YES	Cancer	☐ NO	☐ YES
Prolonged Bleeding	☐ NO	☐ YES	Tuberculosis	☐ NO	☐ YES	Bone Disorders	☐ NO	☐ YES
Anemia	☐ NO	☐ YES	Bronchitis	☐ NO	☐ YES	Growth Disorders	☐ NO	☐ YES
Blood Disease	☐ NO	☐ YES	Asthma	☐ NO	☐ YES	Mouth Breather	☐ NO	☐ YES
Developmental Disorder	☐ NO	☐ YES	Epilepsy	☐ NO	☐ YES	Herpes (Fever Blisters)	☐ NO	☐ YES
Hives/Rash	☐ NO	☐ YES	Fainting	☐ NO	☐ YES	Tonsillitis	☐ NO	☐ YES
For Women only: Are you pregnant or do you think you are pregnant	☐ NO	☐ YES				Are you nursing?	☐ NO	☐ YES
Are you currently taking any medications for Osteoporosis?	☐ NO	☐ YES				List: _____		

Is there any other condition or problem that you think we should know about? _____
_____
Comments: _____

DENTAL HISTORY

Dentist's Name: _____ Address _____ Phone_____
Dental Specialist Name: _____ Address _____ Phone_____

Frequency of dental checkups: Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never ☐ Date of last visit _____
Is there any unfinished care to be completed with your dentist? ☐ No ☐ Yes Explain: _____
Are you frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Have you had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Have you had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Do you play any musical instruments? ☐ No ☐ Yes What Instrument: _____
Have you consulted an orthodontist previously? ☐ No ☐ Yes With whom? _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes _____
Have you had any previous orthodontic treatment? ☐ No ☐ Yes With whom? _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____
Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐ Yes Explain: _____

What are the chief concerns you have related to the position of your teeth or bite:
☐ Appearance ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability ☐ Function
Please elaborate: _____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:
☐ Wear or fractures of teeth ☐ Difficulty with cleaning related to alignment of teeth
☐ Bone or gum tissue loss ☐ Jaw joint or muscle tightness or discomfort
☐ Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
☐ Other

Please check if there is a history of:
☐ Clenching teeth ☐ Muscular soreness around head & neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (If so, which sounds_____) ☐ Mouthbreathing: Awake___ Asleep____

Is there any other information that may be helpful? _____

_____ _____ Reviewed by: _____
Patient Signature Date