Guilford, Hamden & East Haven/Branford Locations

(203) 288 – 0900

www.dr-orthodontics.com

PATIENT INFORMATION *for* ADULTS

Date:_____________________

Full Name: ____ Nickname:________________ Gender: _______

Date of Birth:____________________ Age:_______ SSN:________________________ Marital Status:________________

Address:_________________________________ City: ______________________ State:_________ Zip:_______________

Cell #:__________________________ Home #:_________________________ Email:_______________________________

Has anyone in your family been treated in our office?____

Please CIRCLE how you would you like to receive appointment reminders: Email Text Message Both

Your Employer

Employer: ____________________________________

Occupation: __________________________________

Business phone:_______________________________

Your Spouse

Spouse's Name:________________________________

Spouse's Employer: ____________________________

Cell #:____

Date of Birth:__________________________________

Social Security #:_______________________________

Responsible Party Name:__________________________

How did you hear about our office? Dentist Website Facebook Instagram Friend: __________________

Are you on Facebook? Yes No Please join us @ www.facebook.com/DRorthodontics

Are you on Instagram? Yes No Please join us @ DRorthodontics

MEDICAL HISTORY

Please Circle All Conditions That Apply:

Heart abnormality	Diabetes	Cancer/Tumor	Hearing Impairment
Rheumatic/Scarlet fever	HIV/AIDS	GI Disorder	Speech Disorder
Artificial Heart Valve	Hepatitis	Epilepsy/Seizures	Fainting/Dizziness
High/Low Blood Pressure	Bronchitis	Autism	Nervous/Anxious
Kidney/Liver problems	Asthma	Cleft Lip/Palate	Tactile Defensive
Bleeding Abnormality	Thyroid Disorder	Birth Defect(s)	Major Surgery
Sickle Cell Anemia	Bone Disorder	Growth Disorder	Currently Pregnant
Tuberculosis	Artificial Joints	Tonsils/Adenoids removed	**NONE**

If circled, please explain: ____

Condition not listed: ____

Any allergies? Yes No Please explain: ____

Any medications? Yes No Please explain: ____

TURN OVER

DENTAL HISTORY

Have you previously had any:

Y	N	Abscessed permanent teeth
Y	N	Injured/chipped teeth
Y	N	Periodontal disease/treatment
Y	N	TMJ problems (clicking/pain)
Y	N	Major injuries to jaw/face
Y	N	Jaw/orthognathic surgery

Do you currently have any:

Y	N	Missing permanent teeth
Y	N	Dental implants
Y	N	Active dental decay/cavities
Y	N	TMJ problems (clicking/pain)
Y	N	Clenching/grinding habits
Y	N	Retainers (fixed or removable)

If yes, please explain: ______________________________

Patient's Dentist: ____________________ Last Dental Visit: ____________

Do you currently have any planned dental treatment? Yes No Please explain: ____________

____

Any previous orthodontic treatment? Yes No If yes, at what age: ____________

Any recent orthodontic consultations? Yes No If yes, how long ago: ____________

What treatment was recently recommended? ______________________________

What would you like orthodontics to accomplish? ______________________________

____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the practice of any medical or dental changes to this record.

Patient's Signature: ____________________ **Date:** ____________

OFFICE USE ONLY

Right: Class I Class II______ Class III______ X-B______

Left: Class I Class II______ Class III______ X-B______

OJ: __________ **OB**: Ideal Deep ________ Open _______

Upper: Crowding ____________ Spacing ____________

Lower: Crowding ____________ Spacing ____________

Other: ______________________________

____

____

Perio Clearance: Yes No

Tx Plan: ______________________________

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Est. Fee: ____________ **Est. Time:** ____________