Welcome to Alexander Orthodontics: Please answer the following questions so we can better assist you.

ADULT PATIENT INFORMATION

Patient's Name LAST_____FIRST_____MI_____Prefered Name_____Gender: M F

Birthdate_____Age_____Home Phone_____Work Phone_____Cell Phone_____

Home Address STREET_____CITY_____STATE_____Zip_____

Employer_____Occupation_____

Email Address_____

Who may we thank for referring you to our office?_____

Emergency Contact _____

Phone _____

PERSON RESPONSIBLE FOR FINANCIAL ACCOUNT

Name LAST_____FIRST_____MI_____ Relationship to patient: Self Other: _____

Address STREET_____CITY_____STATE_____Zip_____

Home Phone_____Work Phone_____Cell Phone/Other Phone_____

Social Security #_____Birthdate_____Employer_____

Occupation_____ Is the patient covered by orthodontic insurance? Y N

If the patient is covered by orthodontic insurance, please give card to front desk to check benefit

Marital status: Married _____ Separated _____ Divorced _____ Widowed _____ Single _____

If Married:
Spouse's Name LAST_____FIRST_____MI_____Employer_____

Social Security #_____Birthdate_____Occupation_____

PATIENT MEDICAL HISTORY

Physician's Name_____ Date of last visit_____

Is patient currently in good health?	Y	N	If NO explain:_____
Is patient currently under the care of a physician?	Y	N	If YES explain:_____
Is patient taking any medications?	Y	N	List them / Reason: _____
Any history of serious illnesses or operations?	Y	N	Explain: _____

Has the patient had any allergic reactions to the following:

Dental Anesthetics	Y	N
Penicillin or other Antibiotics	Y	N
Aspirin or Ibuprofen or Tylenol	Y	N
Codeine	Y	N
Any Metal / Plastics	Y	N
Latex or Balloons	Y	N

Are you aware of the patient being allergic to any other foods, medications or substances?
If yes, please list _____

Is there any other Medical Information that we should know about? _____

_____

_____

Women Only: Is the patient taking Birth control pills? Y N Is the patient pregnant? Y N

Circle any of the following which the patient has had, or presently has:

Anemia / Abnormal Bleeding	Asthma / COPD / Difficulty Breathing	Arthritis	Artificial Bone / Joint / Heart Valve
AIDS / HIV+	Blood Transfusion	Hospitalized for Any Reason	Bone Disorders
Cancer / Chemotherapy / Radiation	Congenital Heart Defects	Diabetes	Drug / Alcohol Abuse
Epilepsy / Seizures / Fainting	Glaucoma	Endocrine Problems	Fever Blisters / Herpes
Heart Disease / Attack / Stroke	Hepatitis / Jaundice	High / Low Blood Pressure	Kidney Problems
Tuberculosis (TB)	Psychiatric Treatment	Rheumatic Fever / Scarlet Fever	Sinus / Hay Fever Problems
Severe / Frequent Headaches	Ulcers / Colitis	Venereal Disease	Other: _____

~Please continue on next page~

ADULT PATIENT DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?_____

_____

Patient's Dentist's Name_____ Date of last dental exam _____

Does the patient have any pending dental work that needs to be done?	Y N
Has the patient had any previous orthodontic treatment?	Y N
Has the patient ever been evaluated for orthodontic treatment?	Y N
Has the patient ever had gum surgery or oral surgery?	Y N
Has the patient ever had a bad experience while having any dental work?	Y N
Has the patient had any injuries to the face, mouth, teeth or chin?	Y N
Do the patient's gums ever bleed?	Y N
Does the patient have trouble breathing through their nose?	Y N
Have tonsils or adenoids been removed?	Y N
Has the patient ever been informed of any missing or extra permanent teeth?	Y N
Does the patient have any speech problems?	Y N
Has the patient ever had treatment for jaw joint problems?	Y N
Does the patient's jaw make popping or clicking noises?	Y N
Does the patient have frequent headaches or facial pain?	Y N
Does the patient use tobacco products?	Y N

Please comment on any of the above questions that you answered YES to: _____

_____

_____

DOES THE PATIENT HAVE A HISTORYOF THE FOLLOWING HABBITS?

Circle if there is a history of:

Clenching Teeth Grinding Teeth Thumb/Finger Sucking Lip Sucking/Biting Nail Biting Mouth Breathing Tongue Thrust

Other:_____

IS THERE ANY OTHER INFORMATION THAT MAY BE HELPFUL?

_____

_____

_____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of changes in my medical and dental status. I authorize the doctors and orthodontic staff in this office to perform any necessary dental services that may be needed during the diagnosis and treatment.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or on my dependents behalf. I authorize the doctor and/or any provider or supplier of services in this office to release information required to secure the payment of benefits. I authorize the use of my signature below on all insurance submissions.

I authorize Alexander Orthodontics to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____ _____ _____

Signature / Parent and/or Guardian Date Please Print Your Name

STOP HERE – To be filled out after initial examination – STOP HERE

With my signature below I agree to allow Alexander Orthodontics to take orthodontic records of me. I further recognize that I am responsible for the cost of these orthodontic records, which are necessary for diagnosis and the development of an individualized treatment plan. If treatment is started at Alexander Orthodontics, the records fee is included in the full treatment fee. If it is decided that orthodontic treatment will not be initiated or that treatment will proceed at another location, I agree to pay the expense of the records.

_____ _____

Signature Date