



ADULT

Patient Name _____ Sex: M F
Last First Middle

Name Patient Prefers to be called _____ Date of Birth _____

Address _____ Social Security # _____
Street City Zip

Business Phone _____ Home Phone _____ Other Phone #'s _____

Patient's Dentist _____ Last Visit to Dentist _____

Patient's Physician _____ Last Visit to Physician _____

Employer _____ Marital Status _____

Whom may we thank for referring you to us? _____

Do you plan to relocate out of the area in the near future? _____ If so, when? _____

Which office location is most convenient for you? Pensacola Pace Jay

Are you under any medical treatment now? YES NO If so, what? _____

List any medications you are currently taking _____

List any drug allergies/sensitivities _____

Is there a history of serious illness, accident, surgery, or other condition? _____

Have you had any injury/trauma to your jaws? YES NO If so, what? _____

Have you had any of the following diseases or medical problems?

- | | | |
|-----------------------------|---------------------------|--------------------------|
| Y N Head or Facial Injury | Y N Heart Murmur/Problems | Y N Cancer/Chemotherapy |
| Y N Tonsillitis | Y N Arthritis | Y N Hearing Disorder |
| Y N Hepatitis/Liver Disease | Y N Venereal Disease | Y N High Blood Pressure |
| Y N Rheumatic Fever | Y N Epilepsy/Seizures | Y N Emotional Problems |
| Y N HIV+/AIDS | Y N Bleeding Problems | Y N Nervous Problems |
| Y N Kidney Disease | Y N Diabetes | Y N Endocrine Problems |
| Y N Allergies or Asthma | Y N Ear Infections | Y N Jaw Joint Pain (TMJ) |
| Y N Metal Allergies | Y N Osteoporosis | |

Have you been informed of any missing or extra permanent teeth? _____

Has an Orthodontist been consulted previously or have you had previous Orthodontic treatment? YES NO

If so, by whom? _____

What part of your Orthodontic problem concerns you most? _____

Additional information which you feel would make your experience with us more enjoyable: _____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in the medical status.

Patient Signature _____ Date _____