FOREVER SMILES
ORTHODONTICS

Adult Orthodontic Acquaintance & Health Form

Part I. Patient Information Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Children: _____

Main phone number: _____ Can this phone number receive text messages? Y or N

Email: _____ Social Security #: _____

Occupation: _____ Employer: _____

Do you have dental insurance? Y or N If yes, insurance company name: _____

Policy Holder's Name: _____ Date of Birth: _____ SSN: _____

Are you the person that will be financially responsible for this account? Y or N If not, who? _____

Part II. Medical History

PCP: _____ City: _____ Last visit: _____

Please list any medical condition(s) you have: _____

Please list any medication(s) you currently take: _____

Are you allergic to: Latex? Y or N Nickle? Y or N Medications? Y or N If yes, list: _____

Have you had any hospitalizations or surgeries in the last 5 years? Y or N If yes, list: _____

Part III. Dental History

Dentist: _____ City: _____ Last visit: _____

Do you have any pain in your mouth currently? Y or N If yes, please explain: _____

Have you had any of the following: Gum Disease? Y or N Bleeding/swollen gums? Y or N Deep cleanings? Y or N

Head/ facial trauma? Y or N Clicking noise of the jaw? Y or N Pain in jaw joints/TMJ? Y or N Locked jaw? Y or N

Have you had prior orthodontic treatment? Y or N If yes, please explain: _____

Have you had a previous orthodontic consultation? Y or N If yes, when & where? _____

What improvements would you like to see? _____

How did you hear about our office? _____

I have answered the questions on this form to the best of my knowledge _____
and have been informed of the Notice of Privacy Practices of this office. Patient Signature