



Nicole Connors Smith
—DMD • MSD—
ORTHODONTICS

WELCOME TO OUR OFFICE

Today's Date: _____

So that we become better acquainted, please complete both sides of this form.

ADULT PATIENT HISTORY

Name: _____ Nickname: _____ Sex: _____

Date of Birth: ___/___/___ Age: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____ City: _____ State: _____ ZIP: _____

E-mail Address: _____ Hobbies/Sports: _____

General Dentist: _____ Phone Number: _____ Last Visit Date: _____

Person Responsible for the Account: _____

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

Other family members seen by us: _____

Your Social Security # _____ Occupation: _____

Employer: _____ Work Phone #: _____

Marital Status: Single Married Separated Divorced Widowed

Spouse Information:

His/Her Name: _____ Date of Birth: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: _____

Dental Insurance Information:

Insured's Name: _____ Relationship: _____ Employer: _____

Date of Birth: ___/___/___ Social Security Number: _____ Group #: _____

Insurance Company: _____ Insurance Phone #: _____

Are you covered by another dental plan? Yes No. If yes, please complete the following

Insured's name: _____ Relationship: _____ Employer: _____

Date of Birth: ___/___/___ Social Security Number: _____ Group #: _____

Insurance Company: _____ Insurance Phone #: _____

Dental History

Have you ever been evaluated for orthodontic treatment before?	Yes	No
Have you had previous orthodontic treatment?	Yes	No
Have you ever had a serious/difficult problem associated with any previous dental work?	Yes	No
Have there been any injuries to the face, mouth, teeth or chin?	Yes	No
Do you require antibiotics before dental treatment?	Yes	No
Have adenoids or tonsils been removed?	Yes	No
Do you have any missing or extra permanent teeth?	Yes	No
Have you ever had any pain/tenderness in your jaw joint? (TMJ/TMD)?	Yes	No
What are the main concerns you would like orthodontics accomplish?	_____	

Medical History

Who is your Physician: _____ Phone #: _____ Date of Last Visit: _____

Your Current Physical Health is: Good Fair Poor

Are you currently under the care of a physician: Yes No

If yes, please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each drug you are taking and why _____

Have you ever taken Phen-Fen?

 Also known as Redux or Pondimin Yes No

For Women: Are you taking birth control pills Yes No

Are you pregnant? Yes No If yes, Week # _____

Are you nursing? Yes No

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

- | | | |
|-------------------------------------|---------------------------------------|--------------------------------|
| Y N Abnormal Bleeding Hemophilia | Y N Herpes/Fever Blisters | Y N AIDS |
| Y N High Blood Pressure | Y N Alcohol/Drug Abuse | Y N HIV |
| Y N Anemia | Y N Hospitalized for any reason | Y N Arthritis |
| Y N Kidney Problems | Y N Artificial Bones/Joints/Valves | Y N Liver Disease |
| Y N Asthma | Y N Low Blood Pressure | Y N Blood Transfusion |
| Y N Lupus | Y N Cancer/Chemotherapy | Y N Mitral Valve Prolapse |
| Y N Colitis | Y N Pacemaker | Y N Congenital Heart Defect |
| Y N Psychiatric Problems | Y N Diabetes | Y N Radiation Treatment |
| Y N Difficulty Breathing | Y N Rheumatic/Scarlet Fever | Y N Emphysema |
| Y N Seizures | Y N Epilepsy | Y N Shingles |
| Y N Fainting Spells | Y N Sickle Cell Disease/Traits | Y N Frequent Headaches |
| Y N Sinus Problems | Y N Glaucoma | Y N Stroke |
| Y N Hay Fever | Y N Thyroid Problems | Y N Heart Attack/Surgery |
| Y N Tuberculosis | Y N Heart Murmur | Y N Ulcers |
| Y N Hepatitis | Y N Venereal Disease | |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|---------------------------|-----------------------|---------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex | Y N Other |

Please list any other drugs/materials that you are allergic to: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform necessary dental/orthodontic services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize Dr. Smith to release all information necessary to secure the payment of benefits and I assign directly to Dr. Smith all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submission, whether manual or electronic.

Signature

Date

Office use only

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein

Signature of Dentist

Date