

**ADULT PATIENT INFORMATION & HEALTH HISTORY**

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status: Single\_\_ Married\_\_ Widowed\_\_ Separated\_\_ Divorced\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name(if applicable) \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_

Spouses Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**Primary Insurance:**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

**Secondary Insurance:**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_  
Street City Zip

Phone \_\_\_\_\_

Signature \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? \_\_\_\_\_
- Yes No Are you allergic to any medication? \_\_\_\_\_
- Yes No Do you have a history of a major illness? \_\_\_\_\_
- Yes No Have you had any operations? \_\_\_\_\_
- Yes No Have you ever been involved in a serious accident? \_\_\_\_\_
- Yes No Have you ever smoked or chewed tobacco? \_\_\_\_\_
- Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_
- Female Patients only:
- Yes No Are you pregnant? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

- |                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Hepatitis/Liver problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma or Hayfever           | Gastrointestinal Disorders | HIV / Aids               | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

**DENTAL HISTORY**

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_  
What concerns you most about your teeth? \_\_\_\_\_

- Yes No Are you presently in any dental pain? \_\_\_\_\_
- Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_
- Yes No Have your wisdom teeth been removed? \_\_\_\_\_
- Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_
- Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_
- Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Are you a mouth breather? \_\_\_\_\_
- Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_
- How did they feel about the result? \_\_\_\_\_
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_
- Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_
- Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_
- Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_
- Yes No Do you have "tension" headaches? \_\_\_\_\_

**BENEFITS**

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Jeffrey S. Mastroianni, D.M.D., M.S. to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_