ADULTS

WELCOME TO OUR OFFICE

PATIENT INFORMATION AND HEALTH SURVEY

ADULTS

Welcome to our office. Please fill out both sides of form.

Patient's Name_______________ Age _______ Birth date __________ Sex M F

Street Address _______________ City __________ State ______ Zip Code ________

Home Phone _______________ Cell Phone _______________

Employer_______________ Business Phone _______________

Occupation_______________ Email _______________

Marital Status_______________

Social Security Number _______________

Person responsible for financial matters

Name(s)_______________ Birth date_______ Social Security No. ________

Street Address _______________ City __________ State ______ Zip Code ________

Home Phone_______________ Business Phone _______________

Place of Employment_______________ Email _______________

Driver's License # _______________

	Family Dentist	Family Physician
Name		
Address		
City, State		

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

How else have you heard about us? ❐Dentist ❐Friend ❐Family ❐School ❐Sports ❐Community Event

Other _______________

Reason for orthodontic consultation?_______________

Has anyone in your family had a similar problem? No❐ Yes❐

Are you self-conscious about your teeth? No❐ Yes❐

INSURANCE INFORMATION

Are you covered by insurance for orthodontic treatment? No❐ Yes❐

Insured Name _______________ Insured Date of Birth_______________

Insured Employer _______________ Insured SSN#_______________

Insurance Company_______________ Insurance ID#_______________

Insurance Verification Phone Number_______________

Insured Claims Address_______________

MEDICAL HISTORY – Has the patient ever had any of the following? (please circle)

AIDS	Bleeding	Emotional Problems	Hepatitis	Previous Surgery
Allergy	Bone Loss/Disorders	Epilepsy/Seizures	Herpes	Rheumatic Fever
Anemia	Cold Sores	Hearing Problems	Kidney Disease	Thyroid Problems
Arthritis	Diabetes	Heart Condition	Lung Disease	Other (describe below)
Asthma	Endocrine Problems	Head or Face Injuries	Oral Ulcer	

Comments _______________

Has the patient been under the care of a physician during the past two years, other than for routine examinations?

No❐ Yes❐

Condition _______________

Date of last medical exam _______________

Do you require antibiotic premedication for dental procedures? No❐ Yes❐

Present drugs or medications_______________

Birth Defects: ____________________

Patient's Height: ____________________

RESPIRATORY HISTORY

- Do you have allergies to:
  - Drugs: ____________________
  - Food: ____________________
  - Seasonal Grasses: ____________________
  - Other: ____________________
- Breathe through mouth? Seldom☐ Sometimes☐ Usually☐
- Snore when sleeping? No☐ Yes☐
- Have frequent colds? No☐ Yes☐
- Have frequent "Stuffy Nose?" No☐ Yes☐
- Have frequent sore throat or tonsillitis? No☐ Yes☐
- Have difficulty chewing or swallowing? No☐ Yes☐

Have you received medical treatment from an allergist or ear, nose, and throat specialist? No☐ Yes☐

If yes: When:____________________ By Whom:____________________

Nasal Surgery☐ Tonsils removed☐ Adenoids removed☐

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Have you had any unusual dental experiences? No☐ Yes☐

Specify ____________________

Any injuries to the mouth, teeth or face? No☐ Yes☐

Specify ____________________

Date of last dental checkup ____________________ Were your teeth cleaned? No☐ Yes☐

Have you had an orthodontic consult or treatment? No☐ Yes☐

If yes, please indicate when and where____________________

Do you have Headaches?☐ Neck Pain?☐ Jaw Pain?☐ Ear Pain?☐ Face Pain?☐ Eye Pain?☐ Other?☐

Which side hurts? Right?☐ Left?☐ Both?☐

How long have you had these symptoms?

Years__________ Days__________ Months__________

Is the pain constant?☐ Aching?☐ Shooting?☐ Burning?☐ Stabbing?☐ Electrical?☐ Other?☐

Worse in the afternoon?☐ Worse in the morning?☐ Does it hurt to chew?☐ Does it hurt to open wide?☐

Does your jaw ever make a popping noise?☐ Clicking?☐ Grinding?☐ Other?☐

Has your jaw ever "locked" or slipped out of place? No☐ Yes☐

Do you ever clench or grind your teeth? No☐ Yes☐

During the day?☐ During the night?☐

Do you have problems with your ears?☐ Hearing?☐ Dizziness?☐ Other?☐

Is it difficult to swallow?☐ Painful?☐

Are the teeth sore or sensitive? No☐ Yes☐

Additional comments____________________

____

Patient Signature____________________ Date____________________

Doctor Signature ____________________ Date ____________________

ADULT PATIENT INTEREST SURVEY

Patient Name______________________________________

Welcome to Bernstein Orthodontics. We look forward to treating you. To get to know you better, please complete our short questionnaire.

- What are your favorite activities/hobbies?____
- Do you like sports? _____Yes _____No

  If so what is your favorite team?____

- What college do you attend or have attended?____
- What is your favorite type of music?____
- Who is your favorite singer or band?____
- What is your favorite food or restaurant?____
- What is your favorite TV show or movie?____
- What is your favorite vacation spot?____