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CURTIS ORTHODONTICS

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Member
American Association of
Orthodontists

PATIENT INFOMATION
(Adult)

PATIENT NAME (Dr./Mr./Mrs./Miss/Ms.): _____ DATE: _____/_____/_20_____

BIRTH DATE: _____ SEX: F or M

ADDRESS: _____CITY:_____ ZIP:_____ Home Phone: (___)____-_____

Work: (____)____-_____ Mobile: (____)____-_____

EMAIL / TEXT MSG (appointment reminders): _____@ _____

Occupation:_____ Employer:_____

Name of your physician: _____Date of Last Visit: _____

Name of your dentist: _____Date of Last Visit:_____

Billing party _____

Do you have orthodontic insurance benefits? Yes No Don't Know

Primary Dental Insurance _____Phone: (____)____-_____

Insured Person _____

SSN _____-_____-_____ DOB_____/_____/_____

Insurance ID#_____ Group#_____

1. Do you have a health problem? …….. Yes No Don't Know
   If yes, explain: _____
   _____
2. Have you ever been hospitalized, had general anesthesia, or emergency room visits?
   Yes No Don't Know
   If yes, explain: _____
   _____
3. Do you have allergies to medications (drugs), medical products (latex), or the environment (dust, mites, pollen, mold)? ..... Yes No Don't Know
   If yes, please list: _____
4. List daily medications you are now taking: _____

5. Have you ever had or been treated by a physician for:

Check one for each condition

Yes	No	?		Yes	No	?	
			a. Problems at birth				p. Cancer
			b. Heart Murmur				q. Cerebral palsy
			c. Heart disease				r. Seizures
			d. Rheumatic fever				s. Asthma
			e. Anemia				t. Cleft lip/palate
			f. Sickle cell anemia				u. Speech or hearing problems
			g. Bleeding/hemophilia				v. Eye problems/contact lenses
			h. Blood transfusion				w. Skin problems
			i. Hepatitis				x. Tonsil/adenoid/sinus problems
			j. AIDS or HIV+				y. Sleep Problems
			k. Tuberculosis				z. Emotional/behavior problems
			l. Liver disease				aa. Radiation therapy
			m. Kidney disease				bb. Growth problems
			n. Diabetes				cc. Attention deficit disorders
			o. Arthritis				dd. Osteoporosis (medicine:_____)

6. What is your main concern about your dental condition? _____

_____

DENTAL HISTORY

Check for each condition:

Yes	No	?	
			a. Does your gums bleed when brushed?
			b. Do you have any clicking or pain in the jaw joint?
			c. Do you have any problems opening or closing their mouth?
			d. Have you ever injured your teeth?
			e. Have you ever injured your jaws or face?
			f. Have you received orthodontic treatment in the past?
			Prior orthodontist:_____ Length of treatment:_____
			History of retainer wear: _____
			Status/history of third molars (wisdom teeth): _____
			f. Are you interested in whitening your teeth?
			g. Have you been advised by your physician/dentist to take antibiotics prior to dental treatment?

7. Do you have any other dental problems we should know about? Yes No Don't Know

Please explain:

_____

_____

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

_____

Signature

Patient Name: _____ Date: _____

(Adult)
Are you interested in: (Please indicate all that apply)

- ☐ Information
- ☐ Treatment at this time
- ☐ Clarification of previously received or conflicting information

If your teeth were to be changed, how would you like them change?

- ☐ Upper teeth Forward/Backward
- ☐ Lower teeth Forward/Backward
- ☐ Upper teeth up because gums show too much
- ☐ Close spaces Upper/Lower
- ☐ Straighten crowded teeth Upper/Lower

Are you aware that orthodontic treatment can to some extent alter facial appearance?

Yes No (Circle One)

If any features of the face could be changed, what would you like to see?

- ☐ Upper lip Forward/ Backward
- ☐ Lower lip Forward/ Backward
- ☐ Upper jaw Forward/ Backward
- ☐ Lower Jaw Forward/ Backward
- ☐ Chin Larger/ Smaller
- ☐ Nose Larger/Smaller/Different Shape

Is there any significant family history of jaw or teeth problems?

_____

_____

_____

_____

_____

Are you interested in improving the appearance of the teeth at this time even if more treatment will be needed later? Yes No (Circle One)

_____ _____

Signature Relationship to Patient