5926 W. Parker Rd Ste 300
Plano, TX 75093
972-378-6998

HEALTHY SMILES. BEAUTIFUL FACES.

5410 Alpha Rd
Dallas, TX 75240
972-387-9770

Adult New Patient Form

PATIENT INFORMATION

Date of examination: _____

Name : _____
First MI Last Preferred Name

DOB: _____ Age: _____ Sex: _____ SS# _____ Marital Status: _____

Address: _____

City: _____ State_____ ZIP: _____

How long at this address? _____ DL#: _____ State: _____

Cell Phone: _____ Work phone: _____ Alt phone: _____

Would you like to sign up for e mail or text message reminders of your appointments? Email ☐ Text ☐

E-Mail:_____ Phone # to receive text reminders: _____

Previous address if less than three years: _____

Employer Name:_____

Employer Address: _____

City: _____ State: _____ ZIP: _____

Number of years employed: _____ Occupation: _____

General Dentist _____ Phone: _____ Address: _____

Physician: _____ Phone: _____ Address: _____

Sports / Hobbies: _____

Who may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

SPOUSE INFORMATION

Name : _____
First MI Last Preferred Name

DOB: _____ Age: _____ Sex: _____ SS# _____

Address: _____

City: _____ State_____ ZIP: _____

How long at this address? _____ DL#: _____ State: _____

Cell Phone: _____ Work phone: _____ Alt phone: _____

Employer Name:_____

Employer Address: _____

City: _____ State: _____ ZIP: _____

Number of years employed: _____ Occupation: _____

I hereby acknowledge that I have received a copy of the Privacy Notice.

Signature: _____ **Date:** _____

INSURANCE INFORMATION

Coverage: Orthodontic: ☐ yes ☐ no

Insurance Company Name: _____ Insurance phone: _____

Insurance address: _____City: _____ State: _____ ZIP _____

Identification number: _____ Group number: _____

Who is the primary policy holder? ☐ Parent ☐ Self ☐ Spouse ☐ Other

Name : _____
First MI Last Preferred Name

DOB: _____ SS# _____ Home/ Cell Phone number: _____

Medical: ☐ yes ☐ no

Insurance Company Name: _____ Insurance phone: _____

Insurance address: _____City: _____ State: _____ ZIP _____

Identification number: _____ Group number: _____

Who is the primary policy holder? ☐ Self ☐ Spouse ☐ Other

Name : _____
First MI Last Preferred Name

DOB: _____ SS# _____ Home/ Cell Phone number: _____

DENTAL INFORMATION

Has the patient seen a general dentist in the last year? ☐ yes ☐ no

Any pain, clicking, or discomfort in or near the ears? ☐ yes ☐ no

Has the mouth, face, or teeth been injured by a fall or accident? ☐ Yes ☐ no

Are you aware of any "gum" problems? ☐ yes ☐ no

Have the patient's tonsils or adenoids been removed? ☐ yes ☐ no

Do you feel the patient can benefit from orthodontic treatment? ☐ yes ☐ no

Is the patient happy with their smile? ☐ yes ☐ no

Does the patient want to improve their smile and bite? ☐ yes ☐ no

Does the patient have or ever had any of the following habits? ☐ yes ☐ no

Cheek, tongue or lip chewing	☐ yes ☐ no	Finger/thumb sucking	☐ yes ☐ no
Clenching teeth	☐ yes ☐ no	Tongue thrusting	☐ yes ☐ no
Mouth breathing	☐ yes ☐ no	Grind teeth	☐ yes ☐ no
Finger nail biting	☐ yes ☐ no	Speech problems	☐ yes ☐ no

Has the patient been examined by an orthodontist before? ☐ yes ☐ no

If yes, when? _____

Have other members of the family had orthodontic treatment? ☐ yes ☐ no

If yes, were you happy with the results? ☐ yes ☐ no

If no, why: _____

_____

In your own words, what is the chief orthodontic concern? _____

_____

What would you like orthodontic treatment to accomplish? _____

_____

MEDICAL INFORMATION

Is there a patient history of:

Frequent or severe headaches	☐ yes	☐ no	Heart Murmur	☐ yes	☐ no
Heart Disease	☐ yes	☐ no	Polio	☐ yes	☐ no
Sinus or respiratory disease	☐ yes	☐ no	Diabetic	☐ yes	☐ no
Blood disease	☐ yes	☐ no	Epileptic	☐ yes	☐ no
Liver disease	☐ yes	☐ no	Asthma/hay fever	☐ yes	☐ no
Thyroid disease	☐ yes	☐ no	Tuberculosis	☐ yes	☐ no
Kidney disease	☐ yes	☐ no	Broken bones	☐ yes	☐ no
H.I.V. positive	☐ yes	☐ no	Rheumatism/arthritis	☐ yes	☐ no
Venereal disease	☐ yes	☐ no	Is patient taking medicine?	☐ yes	☐ no
Intestinal disease	☐ yes	☐ no	Fainting/dizziness	☐ yes	☐ no
Bone disease	☐ yes	☐ no	Drug addiction	☐ yes	☐ no
Nervous/emotional problems	☐ yes	☐ no	Yellow jaundice	☐ yes	☐ no
High or Low blood pressure	☐ yes	☐ no	Radiation therapy	☐ yes	☐ no
Endocrine problems	☐ yes	☐ no	Chemical therapy	☐ yes	☐ no
Problems with wounds healing	☐ yes	☐ no	Blood transfusions	☐ yes	☐ no
Tumors or Cancer	☐ yes	☐ no	Hepatitis		
Tonsillitis / Sore throats often	☐ yes	☐ no	Hepatitis A	☐ yes	☐ no
Joint problems	☐ yes	☐ no	Hepatitis B	☐ yes	☐ no
Rheumatic/yellow/scarlet fever	☐ yes	☐ no	Hepatitis C	☐ yes	☐ no
Acquired Immune Deficiency Syndrome	☐ yes	☐ no	other, please specify: _____		
Is patient under medical care?	☐ yes	☐ no	Any allergies or unusual reactions to		
Is patient pregnant at this time?	☐ yes	☐ no	Aspirin	☐ yes	☐ no
Measles/mumps/chicken pox	☐ yes	☐ no	Barbiturates	☐ yes	☐ no
Does patient smoke	☐ yes	☐ no	Sulfa drugs	☐ yes	☐ no
Fever Blisters	☐ yes	☐ no	Penicillin	☐ yes	☐ no
Height and weight normal for age	☐ yes	☐ no	Latex	☐ yes	☐ no
Is patient in good health?	☐ yes	☐ no	Other: _____		
Has patient has a physical this year?	☐ yes	☐ no	List any other allergies or reactions: _____		
Has patient reached puberty?	☐ yes	☐ no	_____		
If male, has patient begun to shave?	☐ yes	☐ no	List any medications currently taking: _____		
If female, has patient begun menstruation?	☐ yes	☐ no	_____		
Anemia	☐ yes	☐ no	Are you aware of any other disease condition or problem		
Hemophilia	☐ yes	☐ no	not listed above that we should know about? _____		
Emphysema	☐ yes	☐ no	_____		

Authorization

I understand that, where appropriate, credit bureau reports may be obtained.

Patient / Parent Signature: _____ Date: _____

Doctor Signature: _____ Date: _____