Andrew Cedarbaum Orthodontics

PATIENT INFORMATION FORM FOR ADULTS

Patient's Name: _____ Preferred Name: _____ Male ❑ Female ❑

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail address: _____ Birth date: _____ Age: _____

Occupation: _____ Social Security #: _____

Employer: _____ Address: _____

Patient's Dentist: _____ Did they refer you to our office? Yes ❑ No ❑

Is there someone other than your dentist whom we may thank for referring you to us? _____

Do you know any patients in our practice? _____

Who noticed an orthodontic problem? Patient ❑ Dentist ❑ Other❑: _____

Please describe the problem in your own words: _____

What concerns you most about orthodontic treatment? ❑ appearance ❑ cost ❑ time ❑ discomfort ❑ results

Patient's interests or hobbies: _____

Family & Account Information

Spouse's Name: _____

Spouse's Work Phone: _____ Cell Phone: _____

Occupation: _____ Social Security #: _____ Birth date: _____

Employer name and address: _____

Children's names and ages: _____

If additional responsible party:

Name: _____ Relationship to patient: _____

Address: _____ City: _____ Zip: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Social Security #: _____ Birth date: _____

Employer name and address: _____

If you have orthodontic insurance, name of insured: _____ ID#: _____

Insurance Co.: _____ Group #: _____

Insurance Co. address: _____ Phone #: _____

If you have dual insurance, name of 2nd insured: _____ ID#: _____

Insurance Co.: _____ Group #: _____

Insurance Co. address: _____ Phone #: _____

MEDICAL HISTORY

Physician's Name: _____ Address _____ Phone: _____

Have you experienced any health problems?	❑Yes	❑No	Explain: _____
Any major changes in your health recently?	❑Yes	❑No	Explain: _____
Are you currently under a physician's care?	❑Yes	❑No	Explain: _____
Are you currently taking any medications?	❑Yes	❑No	List: _____
Are you allergic to any medications?	❑Yes	❑No	List: _____
Have you been in a risk group for HIV?	❑Yes	❑No	Explain: _____
For women: are you pregnant?	❑ Yes	❑ No	Expected delivery: _____

Please check if you have had any of the following conditions:

- ❑ Heart murmur
- ❑ Heart surgery
- ❑ Rheumatic fever
- ❑ Endocrine disorder
- ❑ Prolonged bleeding
- ❑ Anemia
- ❑ Blood disease
- ❑ Developmental/ growth disorder
- ❑ Hepatitis/ liver disease
- ❑ Diabetes
- ❑ Kidney disease
- ❑ Tonsillitis/ adenoids
- ❑ Tuberculosis
- ❑ Bronchitis
- ❑ Asthma
- ❑ Epilepsy
- ❑ Emotional problems
- ❑ Frequent headaches
- ❑ Nervous/anxious
- ❑ Cancer
- ❑ Bone disorders
- ❑ Hives/ rash
- ❑ Fainting
- ❑ Herpes (fever blisters)

Please use this space to further explain any above answers, or if there is any additional problem or condition we should know about:
_____
_____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____

Frequency of dental checkups: _____ Date of last visit: _____

Is there any unfinished care to be completed?	❑Yes	❑No	Explain: _____
Are you frightened about dental treatment?	❑Yes	❑No	Explain: _____
Had a bad experience in a dental office?	❑Yes	❑No	Explain: _____
Have you had any face or dental injuries?	❑Yes	❑No	Explain: _____
Have you consulted an orthodontist previously?	❑Yes	❑No	Who? _____
Have primary or permanent teeth been removed?	❑Yes	❑No	Why? _____
Has there been previous orthodontic treatment?	❑Yes	❑No	With whom? _____
Have you noticed recent changes in your bite?	❑Yes	❑No	Explain: _____
Do you see any dental specialist?	❑Yes	❑No	Who: _____

Please check if there is a history of:

- ❑ Clenching teeth
- ❑ Grinding teeth
- ❑ Speech problems
- ❑ Muscle soreness (head/neck)
- ❑ Tension headaches
- ❑ Mouth breathing
- ❑ Jaw joint soreness
- ❑ Tooth sensitivity
- ❑ Poor oral hygiene
- ❑ Jaw joint popping/clicking
- ❑ Bleeding gums
- ❑ Multiple cavities

What are the chief concerns you have related to the position of your teeth or your bite?:

_____

What concerns has your dentist expressed concerning your bite or dental alignment?:

_____

Please list any other information that may be helpful: _____

_____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I understand that credit bureau reports may be obtained. I authorize Dr. Cedarbaum to perform a complete orthodontic evaluation.

Patient's signature: _____Date: _____