Macomb Orthodontics

Adult New Patient Information Form (Over 18)

Patient Information

Today's Date: _____

Patient's Name: _____
Last | First | Middle | Date of Birth

Address: _____
Street | City | Zip Code

Phone Number: _____ H / W / C _____ H / W / C
Primary Contact | Number Type | Secondary Contact | Number Type

Friends / Family treated here: _____

Email Address: _____

PLEASE FILL IN YOUR PREFERRED METHOD OF APPOINTMENT CONFIRMATION

Phone Call: _____ **Text Message:** _____

Email: _____

How did you hear about Macomb Orthodontics?
(Please circle all that apply)

Friend / Family _____ Name **Dental Professional** _____ Name

Drive By **Newspaper** **Television** **School/ Church Function**

Internet **Direct Mailer** **Team Sponsorship** **Community Event**

Are you on Social Media Yes / No

We Are! Find us on

Responsible Party Information

(Information Required *Only* if Different from Above)

Responsible Party #1: _____
Last | First | Middle

Relationship to patient: _____ **Legal Guardian?** Yes / No

Address: _____
Street | City | Zip Code

Phone Number: _____ H / W / C _____ H / W / C
Primary Contact | Number Type | Secondary Contact | Number Type

Date of Birth: _____ MM/DD/YY **Employer:** _____ **Occupation:** _____

Responsible Party #2: _____
Last | First | Zip Code

Relationship to patient: _____ **Legal Guardian?** Yes / No

Address: _____
Street | City | Zip

Phone Number: _____ H / W / C _____ H / W / C
Primary Contact | Number Type | Secondary Contact | Number Type

Date of Birth: _____ MM/DD/YY **Employer:** _____ **Occupation:** _____

Are the Parties Listed Above Currently Married? **Yes / No**

Emergency Contact Information

(Nearest friend / relative not living with you)

Name: _____
Last | First | Relationship to Patient

Contact Information: _____
Address | Phone Number

Dental Insurance-Primary

Subscriber Name: _____ **Birth Date:** _____

Insurance Company Name: _____ **Phone Number:** _____

Insurance Company Address: _____

Member ID# / SS#: _____ **Group #:** _____

Dental Insurance-Secondary

Subscriber Name: _____ **Birth Date:** _____

Insurance Company Name: _____ **Phone Number:** _____

Insurance Company Address: _____

Member ID# / SS#: _____ **Group #:** _____

Dental History

Dentist Name: _____ **Phone Number:** _____

Address: _____ **Last Visit:** _____ MM/DD/YY

I authorize Macomb Orthodontics to share clinical information with other dental professionals to ensure optimal dental health and best possible results. _____ Signature

Please Circle Yes or No (If Yes, Please provide details)

Is patient presently in any dental pain?	YES / NO	_____
Does patient have bleeding gums or periodontal problems?	YES / NO	_____
Does patient suffer from tooth pain or sensitivity?	YES / NO	_____
Does patient get chronic canker sores in or near the mouth?	YES / NO	_____
Does patient have history of injury to face/mouth/teeth?	YES / NO	_____
Does patient have any thumb/finger-sucking or tongue habits?	YES / NO	_____
Does patient have history of speech problems?	YES / NO	_____
Does patient avoid or struggle with tooth brushing?	YES / NO	_____
Does patient suffer tension headaches, jaw soreness, popping or clicking?	YES / NO	_____
Has patient had any teeth removed? (Baby or Permanent)	YES / NO	_____
Does patient have fear/anxiety over dental appointments?	YES / NO	_____
Is patient self conscious about their teeth?	YES / NO	_____
Has anyone in your family received orthodontic treatment?	YES / NO	_____
Has patient been seen by an orthodontist? If yes, Who and When?	YES / NO	_____

What it your primary concern? (Why are you here today) _____

What would you like to hear about today? (Circle all that apply) Metal Braces Clear Braces Invisalign

General Health History

Physician Name: _____ **Phone Number:** _____

Is the patient pregnant? YES / NO

Does the patient smoke or use tobacco products? YES / NO If yes, How often? _____

Allergies

(If yes, Please list material and reaction)

Does the patient have an allergy to any medications? YES / NO (If yes, list all that apply)

_____ _____

_____ _____

Does the patient have an allergy or sensitivity to Latex / Vinyl / Acrylic YES / NO _____

Does the patient have an allergy or sensitivity to any Metals (Nickel etc.) YES / NO _____

Does the patient have any food allergies? YES / NO _____

Does the patient have seasonal or pet allergies? YES / NO _____

Medications

Please list all medication or supplements the patient is currently taking

Name _____ Taken for _____

Name _____ Taken for _____

Name _____ Taken for _____

Name _____ Taken for _____

Name _____ Taken for _____

Does the patient require pre-medication prior to any dental work YES / NO _____

Does patient or direct family member currently have, or have history of any of the following conditions:
Circle all that apply- (Yes) for patient, (Family) for family member, (No) for no history

Birth Defects	Yes	No	Family	Pneumonia, Tuberculosis, Polio, Mononucleosis	Yes	No	Family
Asthma / Hay Fever	Yes	No	Family	Tumors/Cancer, Radiation or Chemotherapy	Yes	No	Family
Bone Disorders	Yes	No	Family	Bleeding disorder, Abnormal Bruising	Yes	No	Family
Herpes	Yes	No	Family	Gastrointestinal Disorders	Yes	No	Family
Fainting / Dizziness	Yes	No	Family	Neurological Disorder / Epilepsy	Yes	No	Family
HIV / AIDS	Yes	No	Family	Hepatitis, Jaundice or Liver problems	Yes	No	Family
Diabetes	Yes	No	Family	Rheumatoid or Arthritic Conditions	Yes	No	Family
Tonsil/Adnoid Condition	Yes	No	Family	Endocrine or Thyroid problems	Yes	No	Family
Frequent Headaches	Yes	No	Family	Vision, Hearing, Taste or Speech difficulties	Yes	No	Family
Kidney Problems	Yes	No	Family	Heart Problems- Murmurs, Defects, Disease	Yes	No	Family
Abnormal Blood Pressure	Yes	No	Family	Chest Pain, Shortness of Breath, Swollen Ankles	Yes	No	Family
Eating Disorders	Yes	No	Family	Sudden Weight Loss, Poor Appetite	Yes	No	Family
Tires Easily	Yes	No	Family	Mental Health, Depression, Behavioral problems	Yes	No	Family
Sleep Apnea	Yes	No	Family	Substance Abuse	Yes	No	Family

If you answered yes to any question, list details here: _____

Does patient have a history of surgery or hospitalization? YES / NO

If yes, Please explain: _____

Are there any additional medical/mental conditions not mentioned above? YES / NO

If yes, Please explain: _____

Does patient have learning disabilities or need assistance with instructions? YES / NO

If yes, Please explain: _____

Authorizations

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this record of medical or dental status, I will inform the practice.

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

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

Patient Signature (If over 18): _____