Seuss Orthodontics
For the Smile of Your Life

ADULT HEALTH FORM

PATIENT INFORMATION

Patient's name _____ Age _____ Sex: F [ ] M [ ]
Birthdate_____/_____/_____ Marital status _____ SS/ID # _____
Home Address _____ Own [ ] Rent [ ]
City, State _____ Zip _____ How long at address _____
Previous Address (if less than 3 years) _____
Home phone _____ Work phone _____ Cell phone _____
Employer _____ Occupation _____ No. years employed _____
Previous employer (if less than 3 years) _____ No. years employed _____
General Dentist _____ Physician _____
Spouse's Name _____
Employer _____ Occupation _____ No. years employed _____
Social Security # _____ Birthdate_____/_____/_____ Cell phone _____
Who may we thank for referring you to our office? _____
E-Mail address _____

DENTAL INSURANCE INFORMATION

Insured's Name _____DOB _____ SS/ID # _____
Signature of Insured for Assignment of Benefits _____
Employer _____ Relationship to patient _____
Insurance Company _____ Phone # _____
Group # _____ Do you have dual coverage? ___ **YES** ___ **NO**
Insured's Name _____DOB _____ SS/ID # _____

Signature of Insured for Assignment of Benefits _____
Employer _____ Relationship to patient _____
Insurance Company _____ Phone # _____
Group # _____

EMERGENCY INFORMATION

Name of nearest **relative not living with you** _____ (relationship) _____
Address _____ Home phone _____
City, State _____ Zip _____ Work phone _____

I understand the information I have given is correct, I authorize the dental team to perform the necessary dental services I may need. I understand where appropriate, credit bureau reports may be obtained.

Signature _____ Date _____

Patient's name _____

MEDICAL INFORMATION

Please check box if patient has or had any of the following:

Allergies	❑	Endocrine/Thyroid Problem	❑	Latex Allergy	❑
Anemia	❑	Fainting	❑	Liver/Kidney Problem	❑
Asthma	❑	Fever Blisters/Herpes	❑	Nervous/Hyperactive	❑
Blood Transfusion	❑	Frequent Headaches	❑	Prolonged Bleeding	❑
Bone Disorder	❑	Glaucoma	❑	Rheumatic Fever	❑
Cancer	❑	Handicaps/Disabilities	❑	Tobacco Use	❑
Convulsions	❑	Hearing Problems	❑	Tuberculosis	❑
Emotional Problems	❑	Heart Problems	❑	Venereal Disease	❑
Artificial Bones/Joints/Valves	❑	HIV (tested positive)/Aids	❑	Removal of Tonsils/Adenoids	❑
				History of Drug Use	❑

Is patient in good health ? **YES [ ] NO [ ]**
Is patient under physician's care? **YES [ ] NO [ ]**

If so, for what reason _____

Are there any impending medical conditions? **YES [ ] NO [ ]**
If so, describe _____
Is patient taking prescription medications? **YES [ ] NO [ ]**
If so, list _____

For Females only:
Is patient pregnant? **YES [ ] NO [ ]**
Does the patient take birth control pills? **YES [ ] NO [ ]**

DENTAL HISTORY

	YES	NO		YES	NO
Has patient had a recent dental check-up?	❑	❑	Date _____		
Any missing teeth?	❑	❑	Any extra teeth?	❑	❑
Any night time clenching or grinding habit?	❑	❑	Clicking or pain when opening jaws?	❑	❑
Any speech problems?	❑	❑	Surgery to repair cleft lip and/or cleft palate?	❑	❑
Frequent mouth breathing?(awake/sleeping)	❑	❑	Has patient ever seen an orthodontist?	❑	❑

	YES	NO
Have any primary/permanent teeth been removed by extraction?	❑	❑
Would patient mind wearing braces?	❑	❑
Has a dentist ever placed a retainer or space maintainer?	❑	❑
Do you understand some appointments will need to be scheduled during work/school hours?	❑	❑

How many soft drinks consumed daily_____ weekly _____
How many sport drinks consumed daily_____ weekly _____

What are the main concerns you would like orthodontics to accomplish?

_____

_____

_____