

Adult Information Form

Welcome to our office! We are glad you've chosen us for your Orthodontic needs. Our goal is to provide you with the best possible care and service and to make your visit pleasant and educational. So we can get to know you better, please provide us with the information below. If you have any questions or need assistance, we'll be happy to help.

Tell Us About Yourself

Mr. Mrs. Ms. Dr.

Full Name _____ Nickname _____
First Middle Last

Address _____
Street City State Zip

Home # _____ Mobile# _____ E-mail address _____

Birthdate _____ Age _____ Male Female SSN _____

Preferred contact method for appt reminders: Home phone# Work phone# Mobile e-mail

Employer _____ Occupation _____ Work Phone# _____

Hobbies / Sports / Talents: _____

Who May We Thank For Referring You? _____ Friends who also see Dr. Kaplan _____

Marital Status: Single Married Divorced Domestic Partner

Spouse's Name _____ E-mail address _____

Home# _____ Work# _____ Mobile # _____

Employer _____ Occupation _____

Emergency Information

Emergency Contact _____
Neighbor, friend or Relative not living with you. Relationship Mobile# Home phone#

Insurance Information

yes no Orthodontic Coverage? If yes please complete below:

Subscriber's Name _____ Subscriber's DOB _____ Subscribers ID# (SSN) _____

Subscriber's Employer _____ Primary Insurance Company _____ Group# _____ Insurance Co. Phone# _____

Insurance Co Address _____ City _____ State _____ Zip _____

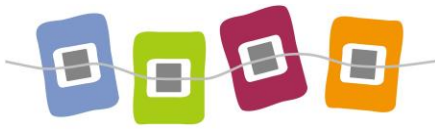
yes no Do you have dual coverage? If yes please complete below:

Subscriber's Name _____ Subscriber's DOB _____ Subscribers ID# (SSN) _____

Subscriber's Employer _____ Primary Insurance Company _____ Group# _____ Insurance Co. Phone# _____

Insurance Co Address _____ City _____ State _____ Zip _____





Medical History

Patient's Physician _____

Date Of Last Visit _____

yes no Are you currently under the care of a physician?

yes no Are you in good health?

yes no Taking medication, nutrient supplements, or herbal medications?

Please list and describe what they are being taken for: _____

yes no Has your physician advised prophylactic antibiotics for dental procedures?

yes no Taking or have taken in the past medications known as "bisphosphonates"? (ie. Fosamax, Boniva, Actonel, Reclast, etc.)

yes no Have you been hospitalized or had any surgery? If Yes, please explain _____

Allergies or reactions to any of the following:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Aspirin? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Ibuprofen (Motrin, Advil)? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Penicillin or antibiotics? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Sulfa drugs? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Latex? (balloons, gloves) | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Acrylic? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Metals? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Foods, nuts, flavorings or colorings? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Reactions to drugs? If so, please explain _____ | | |

- | | | | |
|--|--|--|----------------------------------|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | AIDS or HIV positive? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Headaches, Migranes? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Anemia? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Hepatitis? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Arthritis? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Herpes? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Asthma? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Heart trouble? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Birth Defects/Hereditary problems? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Heart murmur? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Behavioral/Emotional/ Disorders | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | High blood pressure? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Bleeding Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Immune Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Bone Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Kidney Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Bone Fractures? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Liver Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Chew or smoke tobacco? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Muscle Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Cancer or Tumors? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Mental Illness, depression? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Diabetes? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Nervous Disorders? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Dizziness? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Respiratory problems, emphysema? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Eating Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Rheumatic Fever? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Endocrine Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Speech Therapy? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Epilepsy? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Tonsil or Adenoid conditions? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Fainting Spells? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Tuberculosis? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Gastrointestinal Disorders? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Substance abuse past or present? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure | Do you have any disease, condition or illness Not Mentioned Above: | | |

If so, please explain _____

Females

yes no unsure Are you pregnant or is there a chance you are pregnant?

yes no unsure Using birth control pills?





TMJ History

- yes no unsure Do you have pain in your jaw joint?
- yes no unsure Do you experience soreness in the muscles of your face or around ears?
- yes no unsure Do you have difficulty chewing or opening your mouth?
- yes no unsure Do you have a history of jaw problems?
- yes no unsure Have you had a TMJ screening or treated for "TMJ" or "TMD"?
- yes no unsure Do you notice clicking or popping in your jaw joint?
- yes no unsure Do you grind or clench your teeth?
- yes no unsure Do you wear a nite guard?
- yes no unsure Does your bite feel uncomfortable?

Dental History

Patient's Dentist _____ Date of last visit _____ Date of last dental x-rays _____

- yes no Are you currently in any dental pain?
- yes no unsure Is all dental work completed at this time?
- yes no unsure Been under the care of a dental specialist? Specialist: _____

If so for what reason? _____

Have you ever experienced any of the following?

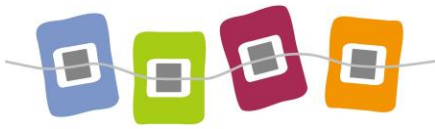
- yes no unsure Teeth sensitive to hot, cold or pressure?
- yes no unsure Periodontal "gum problems"?
- yes no unsure Gums bleed when brushed or flossed?
- yes no unsure Chipped or injured baby or permanent teeth?
- yes no unsure Trauma to the neck, head, or jaw area?
- yes no unsure History of speech problems?
- yes no unsure Mouth breathing habit?
- yes no unsure Snoring or difficulty breathing?
- yes no unsure Abnormal swallowing habit (tongue thrusting)?
- yes no unsure Thumb, finger or lip sucking habit? Until what age? _____
- yes no unsure Frequent canker sores or cold sores?
- yes no unsure Have wisdom teeth been removed?
- yes no unsure Extra or missing teeth from birth?
- yes no unsure Have you had a negative dental experience in the past?

If so, please explain _____

- yes no unsure Are there any dental conditions not mentioned above that you feel we should be aware of?

If so, please explain _____





Orthodontic History

What is your primary concern about your bite, teeth or smile?

- yes no unsure Self-Conscious About Your Smile Or Teeth ?
- yes no unsure Members Of Your Family Had Orthodontic Care Including Yourself?
- yes no unsure Any relative with similar tooth or jaw relationships, ie. Jaw size imbalances?
- yes no unsure Have You Ever Seen Or Been Referred to An Orthodontist?
Where? _____ When? _____
- yes no unsure Would you object to wearing orthodontic appliances should they be indicated?
- yes no unsure Do you have questions about orthodontic treatment?

If yes, please check which applies below:

- Appearance Cost Pain How Long Success

Any Other Concerns? _____

Benefits of Orthodontics: Aesthetics, Health & Function

Orthodontics is a service that provides an improvement in the appearance, function (bite), and general dental health. Teeth change throughout our lifetime and there can be some movement after treatment. Wearing of retainers throughout life will help minimize dental movement.

I understand that the information that I have given is correct to the best of my knowledge, that it will be in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical & dental status. I authorize the dental staff to perform any necessary services needed during the diagnosis & tx . I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Patient Signature

Date

Doctor's Initials

Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Thanks so much for telling us about yourself!!

