Lorin A. Kaplan DDS, MSD
Orthodontic Specialist

Member American Association of Orthodontists

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_____ Subscibers ID# (SSN)_____

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

Insurance Co Address City State Zip

t. 415.479.4543 ▪ f. 415.479.4545 ▪ smiles@kaplanorthodontics.com
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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. Fosamex, Boniva, Actonal, Reclast, etc.)**

❑yes ❑no Have you been hospitalized or had any surgery? If Yes, please explain_____

Allergies or reactions to any of the following:

❑yes ❑no ❑unsure	Aspirin?	❑yes ❑no ❑unsure	Ibuprofen (Motrin, Advil)?
❑yes ❑no ❑unsure	Penicillin or antibiotics?	❑yes ❑no ❑unsure	Sulfa drugs?
❑yes ❑no ❑unsure	Latex? (balloons, gloves)	❑yes ❑no ❑unsure	Acrylic?
❑yes ❑no ❑unsure	Metals?	❑yes ❑no ❑unsure	Foods, nuts, flavorings or colorings?

❑yes ❑no ❑unsure Reactions to drugs? If so, please explain_____

❑yes ❑no ❑unsure	AIDS or HIV positive?	❑yes ❑no ❑unsure	Headaches, Migranes?
❑yes ❑no ❑unsure	Anemia?	❑yes ❑no ❑unsure	Hepatitis?
❑yes ❑no ❑unsure	Arthritis?	❑yes ❑no ❑unsure	Herpes?
❑yes ❑no ❑unsure	Asthma?	❑yes ❑no ❑unsure	Heart trouble?
❑yes ❑no ❑unsure	Birth Defects/Hereditary problems?	❑yes ❑no ❑unsure	Heart murmur?
❑yes ❑no ❑unsure	Behavioral/Emotional/ Disorders	❑yes ❑no ❑unsure	High blood pressure?
❑yes ❑no ❑unsure	Bleeding Disorders?	❑yes ❑no ❑unsure	Immune Disorders?
❑yes ❑no ❑unsure	Bone Disorders?	❑yes ❑no ❑unsure	Kidney Disorders?
❑yes ❑no ❑unsure	Bone Fractures?	❑yes ❑no ❑unsure	Liver Disorders?
❑yes ❑no ❑unsure	Chew or smoke tobacco?	❑yes ❑no ❑unsure	Muscle Disorders?
❑yes ❑no ❑unsure	Cancer or Tumors?	❑yes ❑no ❑unsure	Mental Illness, depression?
❑yes ❑no ❑unsure	Diabetes?	❑yes ❑no ❑unsure	Nervous Disorders?
❑yes ❑no ❑unsure	Dizziness?	❑yes ❑no ❑unsure	Respiratory problems, emphysema?
❑yes ❑no ❑unsure	Eating Disorders?	❑yes ❑no ❑unsure	Rheumatic Fever?
❑yes ❑no ❑unsure	Endocrine Disorders?	❑yes ❑no ❑unsure	Speech Therapy?
❑yes ❑no ❑unsure	Epilepsy?	❑yes ❑no ❑unsure	Tonsil or Adenoid conditions?
❑yes ❑no ❑unsure	Fainting Spells?	❑yes ❑no ❑unsure	Tuberculosis?
❑yes ❑no ❑unsure	Gastrointestinal Disorders?	❑yes ❑no ❑unsure	Substance abuse past or present?

❑yes ❑no ❑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?

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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_____

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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!!

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