downers grove ORTHODONTICS™

ADULT PATIENT INFORMATION

Date / /

Patient Last Name	Patient First Name	Patient Middle Name	Gender ○M ○F

Home Address	City	State	Zip
Mailing Address (If different from Home Address)	City	State	Zip

How Long (Years)	Home Phone	Work Phone	Cell Phone

Previous Address (If less than 3 years at current residence)	City	State	Zip

Date of Birth / /	Age	Social Security Number (SSN)	Marital Status	○Single ○Separated	○Married ○Divorced	○Partnered ○Widowed

Employer	Occupation	How Long Employed (Years)

Employer Address	Employer Phone

Email Address

Spouse Full Name

Spouse Employer	Spouse Occupation	Spouse How Long Employed (Years)

Spouse Employer Address	Spouse Work Phone

Spouse Cell Phone	Spouse Date of Birth / /	Spouse Social Security Number (SSN)

Spouse Email

Who may we Thank for referring you to our office?

Person Responsible for Account	Relation to Patient

PRIMARY ORTHODONTIC INSURANCE INFORMATION

Member Name	Group Number	Member SSN or Member ID
Insurance Company	Insurance Phone	Local Number

SECONDARY ORTHODONTIC INSURANCE INFORMATION

Member Name	Group Number	Member SSN or Member ID
Insurance Company	Insurance Phone	Local Number

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you	Relative's Phone

Relative Address	Relative City	Relative State	Relative Zip

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

Signature ______________________ **Date** ___/___/___

Printed Name ______________________

Updates Date ___/___/___ Initial ____ Date ___/___/___ Initial ____

MEDICAL HISTORY

Physician's Name (First and Last)	Date of Last Visit
Physician's Address	Physician's Phone

Are you taking any medication? ○ Yes ○ No | List medications:

Are you allergic to any medication? ○ Yes ○ No | List medications:

Have you had any operations? ○ Yes ○ No | Details:

Have you ever been involved in a serious accident? ○ Yes ○ No | Details:

Have you ever smoked or chewed tobacco? ○ Yes ○ No | Details:

Have you seen a physician in the last 12 months? ○ Yes ○ No | Why?

Are you allergic to latex? ○ Yes ○ No | Details:

Are you allergic to metals / nickel? ○ Yes ○ No | Details:

Are you allergic to plastics? ○ Yes ○ No | Details:

WOMEN ONLY	Are you pregnant? ○ Yes ○ No	Week #	Are you nursing? ○ Yes ○ No

PLEASE CHECK (X) IF YOU HAVE HAD ANY OF THE FOLLOWING

☐ Abnormal Bleeding / Hemophilia	☐ Diabetes	☐ Hepatitis / Liver Problems	☐ Prolonged Bleeding
☐ Anemia	☐ Drug / Alcohol Abuse	☐ Herpes	☐ Psychiatric Problems
☐ Arthritis	☐ Epilepsy / Fainting	☐ High Blood Pressure	☐ Radiation / Chemotherapy
☐ Asthma or Hayfever	☐ Gastrointestinal Disorders	☐ HIV+ / AIDS	☐ Rheumatic / Scarlet Fever
☐ Blood Transfusion	☐ Handicaps / Disabilities	☐ Kidney problems	☐ Sickle Cell Disease / Traits
☐ Bone Disorders	☐ Heart Murmur	☐ Lupus	☐ Tuberculosis (TB)
☐ Cancer	☐ Heart Attack / Stroke	☐ Nervous Disorders	☐ Tumor
☐ Congenital Heart Defect	☐ Heart Surgery / Pacemaker	☐ Pneumonia	☐ Ulcers / Colitis

Do you have any **other medical conditions** not listed we should be aware of? ○ Yes ○ No | Details:

DENTAL HISTORY

Dentist Name (First and Last)	Date of Last Visit
Dentist Address	Dentist Phone

What concerns you most about your teeth?

Are you presently in any dental pain? ○ Yes ○ No | Details:

Have you ever experienced any unfavorable reaction to dentistry? ○ Yes ○ No | Details:

Have you ever lost or chipped any teeth? ○ Yes ○ No | Details:

Have there been any injuries to face, mouth, or teeth? ○ Yes ○ No | Details:

Is any part of your mouth sensitive to temperature or pressure? ○ Yes ○ No | Where?

Do your gums bleed when brushing? ○ Yes ○ No | Details:

Do you have any type of thumb or tongue habit? ○ Yes ○ No | Details:

Do you have any speech problems? ○ Yes ○ No | Details:

Do you generally breathe through your mouth? ○ Yes ○ No | Details:

Have you ever seen an orthodontist? ○ Yes ○ No | If yes, who and when?

Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? ○ Yes ○ No | Details:

Are you aware of your jaw clicking or popping? ○ Yes ○ No | Details:

Are you aware of clenching your teeth during the day? ○ Yes ○ No | Details:

Have you ever been told that you grind your teeth? ○ Yes ○ No | Details:

Are you aware that some appointments will be during work hours? ○ Yes ○ No

BENEFITS OF ORTHODONTICS: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.
I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

In addition, I authorize Dr. Balakrishnan and her staff to perform a complete orthodontic evaluation.

Signature ______________________ **Date** ____/____/____

Doctor's Comments ______________________

______________________ **Initials** ________ **Date** ____/____/____