



## ADULT PATIENT INFORMATION

TITLE  Dr.  Mr.  Miss  Ms.  Mrs.

NAME \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ GENDER  MALE  FEMALE

ADDRESS (home) \_\_\_\_\_ # OF YEARS @ ADDRESS \_\_\_\_\_

PHONE (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

EMAIL \_\_\_\_\_ SSN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # OF YEARS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

DENTIST \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

HAS PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE?  YES  NO IF SO, WHERE? \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS (home) \_\_\_\_\_

PHONE (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

## ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO MBRACE ORTHODONTICS? \_\_\_\_\_

**Retention of Documents Relating to Patient Care.** By signing this, you understand and agree that it is our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## DENTAL HISTORY

CHECK IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Blisters on lips/mouth     | <input type="checkbox"/> Grinding teeth          | <input type="checkbox"/> Jaw surgery                         | <input type="checkbox"/> Periodontal surgery        |
| <input type="checkbox"/> Broken fillings            | <input type="checkbox"/> Gums bleeding           | <input type="checkbox"/> Lip/cheek biting                    | <input type="checkbox"/> Sensitivity to hot or cold |
| <input type="checkbox"/> Burning sensation, tongue  | <input type="checkbox"/> Gums sore/swollen       | <input type="checkbox"/> Loose teeth (other than baby teeth) | <input type="checkbox"/> Sensitivity to sweets      |
| <input type="checkbox"/> Chews on tongue            | <input type="checkbox"/> Injuries to teeth/jaw   | <input type="checkbox"/> Mouth breathing                     | <input type="checkbox"/> Sensitivity to pressure    |
| <input type="checkbox"/> Dry mouth                  | <input type="checkbox"/> Injuries to face/head   | <input type="checkbox"/> Mouth pain when brushing            | <input type="checkbox"/> Sores/growths in mouth     |
| <input type="checkbox"/> Extracted teeth            | <input type="checkbox"/> Jaw clicking/popping    | <input type="checkbox"/> Orthodontic treatment               | <input type="checkbox"/> Speech problems            |
| <input type="checkbox"/> Finger/thumb habits        | <input type="checkbox"/> Jaw locking open/closed | <input type="checkbox"/> Pain around ear                     | <input type="checkbox"/> Tongue thrust              |
| <input type="checkbox"/> Food trapped between teeth | <input type="checkbox"/> Jaw pain/tenderness     | <input type="checkbox"/> Periodontal treatment               |   |

HOW OFTEN DO YOU BRUSH? \_\_\_\_\_ FLOSS? \_\_\_\_\_

ADDITIONAL COMMENTS \_\_\_\_\_

## MEDICAL HISTORY

CHECK IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Scarlet fever       |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Circulatory problems  | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Cortisone treatment   | <input type="checkbox"/> HIV Positive            | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial heart valves  | <input type="checkbox"/> Coughing - persistent | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Stomach ulcers      |
| <input type="checkbox"/> Artificial joints        | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Swelling of feet    |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Mitral valve prolapse   | <input type="checkbox"/> Thyroid problems    |
| <input type="checkbox"/> Back problems            | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Nervous system problems | <input type="checkbox"/> Tobacco habit       |
| <input type="checkbox"/> Blood diseases           | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Tonsillitis         |
| <input type="checkbox"/> Bone disorders           | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Psychiatric Care        | <input type="checkbox"/> Tonsils removed     |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Radiation treatment     | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Chemical dependency      | <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Respiratory disease     | <input type="checkbox"/> Urinary problems    |
| <input type="checkbox"/> Other (not listed) _____ |  |  |  |

**\*\*FEMALES ONLY\*\*** IS IT POSSIBLE THAT YOU ARE PREGNANT?  YES  NO IF SO, HOW FAR ALONG? \_\_\_\_\_

ARE YOU UNDER THE CARE OF A PHYSICIAN?  YES  NO FOR WHAT CONDITION? \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

## MEDICATIONS ALLERGIES

Please list **ANY & ALL** medications that you are currently taking: Please list **ANY & ALL** known allergies you are aware of:

\_\_\_\_\_  
\_\_\_\_\_

ARE YOU CURRENTLY TAKING OR HAVE TAKEN IN THE PAST ANY BONE DENSITY MEDICATIONS?  YES  NO

(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonafos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. It is my responsibility to inform this office of any changes in my personal information or health status. I will not hold mBrace Orthodontics or the staff responsible for any errors or omissions that I have made in the completion of this form

NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_