UPPER EASTSIDE
ORTHODONTISTS

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Orthodontics & Dentofacial Orthopedics

ADULT PATIENT HISTORY

1. Patient Name _____ Sex Male Female
2. Address_____
   City _____ State _____ Zip _____ Tel (_____) _____
3. Date of Birth _____ Age _____ Cellular#_____
4. Social Security Number_____-_____-_____
5. Employer _____ Occupation_____ Bus Tel _____
   Business Address _____ City _____ State_____ Zip_____
6. Spouse/Partner _____
   Employer_____Occupation_____
   Business Address _____City _____ State _____ Zip _____Tel _____
7. Are you married domestic partner single
8. Do you have insurance that provides for orthodontic care? Yes No
   If yes, please provide Insurance Co. name_____Address_____
9. Policyholder _____ SS#_____ DOB:_____

DENTAL HISTORY

1. Do you have a regular dentist? ___ Yes ___ No Specialist? ___ Yes ___ No
   Dentist's name & address _____
2. When did you last receive dental care? _____ Routine or Emergency (circle one)
3. How frequently do you brush your teeth? _____ Use dental floss? _____
4. Have your teeth or either of your jaws been injured? Yes No if yes, how old were ou?_____
   If yes, what was the cause of the accident? _____
   Which teeth and/or jaw were involved? _____
5. Have you been informed of any missing or extra permanent teeth? _____
6. Do you have any jaw, joint or facial pain?_____
7. Do you have, or have you ever had, any of the following habits (please check) _____ Lip sucking _____ Nail biting
   ____ Lip biting _____ Constant mouth breathing _____ Nail biting _____ Thumb/finger sucking _____ Grinding teeth
8. Do you have any speech problems?_____
9. Does anyone in your family have a similar dental or facial condition?_____
10. Has anyone else in your family received orthodontic care? _____
11. Has an orthodontist been consulted previously? _____

MEDICAL HISTORY

1. Are you in good health? Yes No
2. Describe any major illness _____
3. Physician's Name and Address:_____
4. List any drugs or medications now being taken. Indicate the reason for each _____
   _____
5. List any allergies or drug sensitivities_____
6. Circle any of the following for which you have been treated: Diabetes Tuberculosis Endocrine Problems
   Pneumonia Anemia Prolonged Bleeding Heart Trouble Epilepsy Fainting/Dizziness
   Rheumatic Fever Asthma Nervous Disorders Heart Murmur Immune Disorder
   Bone Disorders Kidney Problem Liver Problem - Hepatitis
7. Do you have a tendency to any of the following _____ Colds _____ Sore Throat _____ Ear Infections?
8. Have your _____ tonsils _____ adenoids been removed? Yes No If Yes, at what age? _____
9. Women: Are you pregnant? Yes

E-mail Address:_____

Patient's Signature _____

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