

Adult Patient Info

Date: _____

Name: _____
Last First MI Nickname or name you prefer: _____

Address: _____
Street City State Zip

How long at this address? _____ Sex: M F Email: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Best phone for reaching you during the day: Home Work Cell

Birthdate: _____ Age: _____ Social Security: _____

Employer: _____ Occupation: _____ Years of employment: _____

Employer's address: _____
Street City State Zip

Dentist: _____ Date of last cleaning: _____

Dentist Address _____
Street City State Zip Dentist Phone: _____

How did you hear about us? _____

Insurance

Cardholder's name (if different from above): _____
Last First MI Birthdate: _____

Relation to insured: _____

Insurance company name: _____

Insurance address: _____
Street City State Zip

Insurance phone: _____ Group name: _____

Insurance ID# or SS#: _____ Group ID#: _____

Secondary Insurance

Cardholder's name (if different from above): _____
Last First MI Birthdate: _____

Relation to insured: _____

Insurance company name: _____

Insurance address: _____
Street City State Zip

Insurance phone: _____ Group name: _____

Insurance ID# or SS#: _____ Group ID#: _____

(continued on back)



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info@orthocenters.org

GENERAL

Describe the primary concern with your teeth: _____

Y N Have you had any prior orthodontic consultation or treatment?

DENTAL

Y N Do you require antibiotics for dental cleanings?

Y N Are you aware of any dental work that needs to be completed (ie: fillings)?

Y N Are you presently in any dental discomfort?

Y N Have you ever had trauma to the head, face or teeth? (if yes, please check all that apply)

Y N Do you have any extra, missing or extracted teeth? (if yes, please check all that apply)

Y N Have you ever had an unfavorable reaction to dentistry?

Y N Do you have TMJ problems (clicking/pain)?

Y N Have your adenoids/tonsils been removed?

Y N Do you brush daily?

Y N Floss daily?

Y N Do you have any gum problems?

Y N Have a finger/thumb habit?

Y N Do you clench/grind your teeth?

Y N Have difficulty chewing?

Y N Do you have any speech problems?

Y N Use any tobacco products?

MEDICAL

Please check any problems or conditions that may apply to you:

Abnormal bleeding/Hemophilia

Epilepsy

Kidney

Anemia

Gastrointestinal

Osteoporosis

Asthma

Heart problem/defect

Psychological/ADD/ADHD

Bone disorder

Heart murmur

Rheumatic/Scarlet fever

Diabetes

Hepatitis/Liver

Tuberculosis

Drug/alcohol use

Herpes/Fever blisters

Tumor/Cancer

Endocrine

HIV/AIDS

Other: _____

Females: Are you pregnant? Y N Week: _____

Do you have allergies to any medications or any other substance? _____

List all medications currently being taken: _____

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I have read and understand the above questions, and this office's privacy policies. I will not hold Innovative Orthodontic Centers responsible for any errors or omissions. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes. I understand, where appropriate, credit bureau reports may be obtained.

Signature _____

Date _____