Westfall ORTHODONTICS

ADULT PATIENT FORMS

Patient Information

First Name:		Middle Name:		Last Name:
I prefer to be called:		SEX: ☐ Male ☐ Female		
What is your chief concern or reason for seeking Orthodontic treatment?				
Birth Date:	Age:	Drivers License Number:		SSN:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated				Home Phone:
Street Address:		City:	State/Province	Zip Code:
Email Address:		Cell Phone:		
Name of Employer:		Work Phone:		
Work Address:		City:	State/Province	Zip Code:
Dentist's Name:		Phone:	Date of Last Visit:	
Physician's Name:		Phone:	Date of Last Visit:	
Other Family Members Seen By Us:				
How did you hear about us?				

Spouse's Information

First Name:		Middle Name:		Last Name:
Birth Date:	Work Phone:	Home Phone:	Cell Phone:	
Street Address(If Different From Patient):		City:	State/Province	Zip Code:
Email Address:		Employer:		

Emergency Contact Information

Name:		Relation To You:	
Home Phone:	Cell Phone:		
Home Address:	City:	State/Province	Zip Code:

Insurance

Insurance Co:	
Group #:	ID #:

Person Responsible Account

Who Is Responsible For This Account?	☐ Self	☐ Spouse	☐ Other
Do you have orthodontic insurance?	☐ Yes	☐ No	

Medical History

Do you currently feel healthy?	☐ Yes	☐ No
Have you ever been evaluated or had orthodontic treatment before?	☐ Yes	☐ No
Have you been informed of any missing or extra permanent teeth?	☐ Yes	☐ No
Have you experienced problems with previous dental work?	☐ Yes	☐ No
Have you ever had any pain / tenderness in your jaw joint (TMJ/TMD)?	☐ Yes	☐ No
Has your jaw ever clicked, popped or locked?	☐ Yes	☐ No
Have you noticed your teeth shifting or a change in your bite?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you still have your wisdom teeth?	☐ Yes	☐ No
Have there been any injuries to your face, mouth, teeth or chin?	☐ Yes	☐ No
Do you need to be premedicated before dental work?	☐ Yes	☐ No
Have adenoids or tonsils been removed?	☐ Yes	☐ No
Do you brush your teeth daily?	☐ Yes	☐ No
Do your gums bleed?	☐ Yes	☐ No
Are you taking fluoride supplements?	☐ Yes	☐ No
Females: Do you take birth control pills?	☐ Yes	☐ No
Females: Are you pregnant?	☐ Yes	☐ No

Please list all medications that you are currently taking:

Are you Allergic to any of the following?

☐ Aspirin ☐ Any Metal ☐ Plastic ☐ Codeine
☐ Dental Anesthetics ☐ Erythromycin ☐ Latex ☐ Penicillin
☐ Tetracycline ☐ Sulfa Drugs ☐ Other ☐ None

Please list any other Allergies that you have:

Do you now have or have you had any of the following habits?

☐ Tongue Thrust ☐ Clenching/Grinding Teeth ☐ Lip Sucking/Biting
☐ Speech Problems ☐ Mouth Breather ☐ Nail Biting
☐ Other ☐ None

Please list any other Habits that you have:

Do you now have or have you had any of the following?

☐ Allergies
☐ Abnormal/Bleeding Disorders
☐ Any Hospital Stays
☐ Astma
☐ Cancer
☐ Canker Sores
☐ Cardiovascular Disease
☐ Chicken Pox
☐ Cold Sores/Fever Blisters
☐ Convulsions/Epilepsy
☐ Damaged/Artificial Heart Valves
☐ Diabetes
☐ Handicaps/Disabilities
☐ Hearing Impairment
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis/Liver Problems
☐ High Blood Pressure
☐ Hives
☐ HIV+/AIDS
☐ Kidney Problems
☐ Measles
☐ Mononucleosis
☐ Psychological Counseling
☐ Rheumatic/Scarlet Fever
☐ Skin Rash
☐ Tuberculosis (TB)
☐ Tumors/Growths
☐ Ulcers
☐ None

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. We reserve the right to verify the credit status prior to extending credit for treatment. I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the medical status of the patient named herein. Additionally, I hereby consent to an initial examination of the patient named herein.

Signature: _____ Date: _____