



We look forward to seeing you: _____ at _____ am / pm
We would appreciate you arriving 10 minutes before the appt time with this form completed.

Today's Date: _____

ADULT FORM

Please take this time to tell us about yourself.

Name: _____
First Middle Last

Mr. Mrs. Ms. Miss Dr.

I prefer to be called _____ Male Female
Nickname

Birth Date _____ / _____ / _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

How long at current address: _____

Single Married Divorced Separated Widowed

Children (Please list names and ages.)

Have any other family been seen in our office? Names: _____

EMPLOYER INFORMATION

Employer: _____

Occupation: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work: (_____) _____ Years of employment ? _____

SPOUSE INFORMATION

His / Her Name: _____

Birth Date: _____ / _____ / _____ Age: _____

Employer: _____

Occupation: _____

Work Phone: (_____) _____ Ext. _____

Years of employment ? _____

Who may we thank for referring you to our office?

INSURANCE

Primary Dental Insurance

Orthodontic Coverage: Yes No

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (_____) _____

Insured Name: _____

Relation to Patient: _____ Birth Date: ____/____/____

SS#: _____ Group #: _____

Secondary Dental Insurance

Orthodontic Coverage: Yes No

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (_____) _____

Insured Name: _____

Relation to Patient: _____ Birth Date: ____/____/____

SS#: _____ Group #: _____

** I hereby authorize the release of any information relating to this claim

Signature _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____ Cell: (_____) _____

E-mail Address: _____

Emergency Contact: _____

Relation: _____ Phone: (_____) _____

I understand that where appropriate Credit Bureau reports may be obtained.

Signature _____

GENERAL DENTIST

Name: _____ Last dental exam _____

My dentist referred me to Waugh and Allen Orthodontics:

Yes Another Orthodontist None

MEDICAL HISTORY

A complete history is vital for a proper orthodontic evaluation.

Physician: _____

Phone No: _____ Date of last visit: _____

Are you taking any prescription medication: Yes No

If yes, please list which one(s): _____

For Women: Are you pregnant? Yes No

Have you ever had any of the following diseases or medical problems? (Please circle all that apply.)

- | | |
|------------------------------------|-------------------------------------|
| Abnormal Bleeding | Hepatitis |
| AIDS or HIV positive | Immune System |
| Artificial Bones / Joints | Jaundice or Liver Problems |
| Asthma | Kidney Problems |
| Birth Defects | Mental Health / Behavioral |
| Blood Pressure-High or Low | Mitral Valve Prolapse |
| Bone Disorders | Nervous Problems |
| Cancer or Tumors | Neurological Problems |
| Chest Pain | Pneumonia |
| Congenital Heart Defect | Polio, Mono or Tuberculosis |
| Convulsions | Prosthetics |
| Diabetes | Radiation / Chemotherapy |
| Ear, Nose or Throat | Rheumatic or Scarlet Fever |
| Endocrine or Thyroid | Rheumatoid / Arthritic |
| Epilepsy | Sickle Cell Disease / Traits |
| Excessive Weight Loss/Gain | Skin Disorders |
| Fainting Spells or Seizures | Speech Difficulties |
| Handicap / Disabilities | Stomach Ulcers/Hyperacidity |
| Hay Fever or Sinus Trouble | Swelling Ankles |
| Hearing Impairment | Tuberculosis |
| Heart Trouble / Murmur | Vision Difficulties |

Any Hospital Stays / Operations? _____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

MEDICAL ALERT INFORMATION

Do you normally require antibiotic pre-medication prior to dental procedures? Yes No _____

Are you allergic to any of the following?

Latex Yes No Plastic Yes No

Nickel Yes No Aspirin Yes No

Erythromycin Yes No Codeine Yes No

List any other allergies: _____

DENTAL HISTORY

Have you ever been evaluated by an Orthodontist? Yes No

If so, by whom? _____

Have you ever had orthodontic treatment? Yes No

If so, by whom? _____

Were you happy with the results? Yes No

Have other members of your family had orthodontic treatment?

Yes No Were you happy with the results? Yes No

By whom (if other than Dr. Waugh)? _____

Chief complaint or reason for your visit today? _____

Appearance

If you could change one thing with the appearance of your teeth or your bite, what would it be? _____

Are you happy with your smile? Yes No

Do you like the shape of your teeth? Yes No

Are you happy with your profile and jaw line? Yes No

Are you happy with the amount of gum tissue that you show when smiling? Yes No

Function

Do you experience pain, clicking or discomfort in or near your ears?

Yes No

Do you have pain or tenderness in your jaw joints (TMJ / TMD)?

Yes No

Have there been any injuries to the face, mouth, teeth or chin?

Yes No

Have you been informed of missing or extra permanent teeth?

Yes No

Are you aware of any gum problems? Yes No

Have your tonsils or adenoids been removed? Yes No

Habits

Do you or did you have any of the follow habits? (Please circle)

Clenching / Grinding Teeth Lip Sucking / Biting

Mouth Breather Nail Biting

Thumb / Finger Sucker (Until: _____ age)

I hereby certify that I have reviewed the above medical and dental history and agree that it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

Patient's Signature

Date

Doctor's Signature

Date