DATA SHEET – ADULT (over 18)

Patient Information

Today's Date _______________

Patient's Name __________________________________ Nickname __________________________________

Address ______________________________________ Gender ___________________________________

____ Birth Date _________________ Age _________

E-mail ____ Work/Home Phone ________________________

Cell Phone______________________________________ SS# ______________________________________

Occupation _____________________________________ Employer __________________________________

Patient's Dentist Name & City____ Date of Last Cleaning ________

How did you hear about our office? ____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Spouse's Name __________________________________ Spouse's Birthdate ________________________

Spouse's Occupation ________________ Employer ______________________ Ph # ______________________

Primary Orthodontic Insurance

Insured's Name _________________________________

Relation to Patient ______________________________

Insured's Birth Date _____________________________

Insured's SS# __________________________________

Insured's Employer ______________________________

Insurance Company ______________________________

Insured's Subscriber # ____________________________

Secondary Orthodontic Insurance

Insured's Name _________________________________

Relation to Patient ______________________________

Insured's Birth Date _____________________________

Insured's SS# __________________________________

Insured's Employer ______________________________

Insurance Company ______________________________

Insured's Subscriber # ____________________________

Dental History

What is your main orthodontic concern? ____

Yes No Have you ever had any significant dental problems? _______________________________________

Yes No Have you ever had periodontal / gum disease? ____

Yes No Do you have a thumb or tongue habit? ____

Yes No Have any teeth ever been injured or knocked out? When?_____________________________________

Yes No Have you ever had orthodontic treatment in the past? When? _________________________________

Yes No Have you seen an orthodontist recently? Who? ____

What is your attitude towards orthodontic treatment? ____________________________________

Yes No Have any family members received orthodontic treatment? ____________________________________

How did they feel about the result? ____

Yes No Do you experience any jaw / TMJ pain? ____

Yes No Does your jaw ever feel tired or sore when you wake up in the morning? _______________________

Yes No Do you have any pending dental treatment planned with the dentist? ___________________________

Yes No Are you aware that some appointments will be during work / school hours? _____________________

Medical History – Adult (over 18)

Patient's Physician ___________________________________
Address ____

Yes No Is there any history of a major illness? ____
Yes No Are you taking any medications? ____
Yes No Do you have any heart problems? ____
Yes No Do you have any implanted pins, plates, or joint replacements that require premedication prior to dental treatment? ____
Yes No Do you need to take premedication prior to dental treatment? _________________________________
Female Patients only:
Yes No Are you pregnant? ____

Are you allergic to any of the following: ___ Latex ___Acrylics ___Metals ___Penicillin
Please list any other drugs/materials you are allergic to: ____

Please place a checkmark below if you have ever had any of the following:

___ Abnormal bleeding/ Hemophilia
___ AIDS/HIV Positive
___ Angina
___ Arthritis
___ Artifical Joint
___ Blood Disorders
___ Bone Disorders
___ Cancer / Tumor
___ Congenital Heart Defect
___ Diabetes
___ Epilepsy
___ Fainting Spells
___ Headaches
___ Heart Problems
___ Hepatitis A, B, or C
___ High Blood Pressure
___ Jaundice
___ Liver Disease
___ Radiation / Chemo
___ Seizures
___ Tuberculosis

Yes No Have you ever had any illness, medical condition, or hospitalizations not listed above?
If yes, please explain ____
Yes No **Are there any precautions we need to take prior to dental treatment?**
If yes, please explain ____

Emergency Contact

Name ____ Relation ____
Address _______________________________________ Phone # ____
____

I understand that the information I have provided is correct to the best of my knowledge, and it will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize release of any information to insurance carriers and to other healthcare providers.
I authorize the application for benefits on my behalf and payment of benefits to the office. I also authorize the doctor to complete an orthodontic evaluation and to perform any orthodontic / dental services that may be necessary during treatment.

Patient Signature : ____ Date: _______________

Dr. Lindgren Signature: ____ Date: ________________