



Patient Information (Adult)

Name _____ / _____
First Middle Last Nickname

D.O.B. _____ Age _____ Gender M F SSN _____ - _____ - _____

Address _____

City _____ State _____ Zip/Postal Code _____

Phone Numbers Home () _____ Cell () _____ Work () _____

E-mail Address _____ I prefer to be contacted at/by _____

Occupation _____ Employer _____

General Dentist _____ Date Last Seen _____

Who may we thank for referring you? _____

Hobbies/Interests _____

I am: single married separated widowed divorced

I am solely responsible for this account yes no

If no, please provide name, address and telephone number of responsible party _____

Emergency Information

Name of person to contact in case of emergency _____

Address _____

Phone () _____ Relationship _____

Insurance Information

Primary Dental Insurance

Company Name _____

Phone Number _____

Group Number _____

Policy Holder s Name _____

D.O.B. _____ SSN _____ - _____ - _____
Employer _____

Secondary Insurance

Company Name _____

Phone Number _____

Group Number _____

Policy Holder s Name _____

D.O.B. _____ SSN _____ - _____ - _____
Employer _____



Dental and Health History

Name _____ D.O.B. _____ Gender M F
 First Middle Last

Dental Orthodontic History	Yes	No	Additional Information
Thumb/ Finger sucking			
Tongue thrust			
Clenching/ grinding teeth			
Mouth breathing habit, snoring or difficulty in breathing			
Chipped or otherwise injured primary (baby) or permanent teeth			
Difficulty in chewing or jaw opening			
Had periodontal (gum) treatment			
Teeth sensitive to hot or cold			
Speech problems			
Supernumerary (extra) or congenitally missing teeth			
Had prior orthodontic examination or treatment			
Bleeding gums, bad taste or mouth odor			
Periodontal "gum problems"			
Any pain or soreness in the muscles of the face or around the ears			
Aware of any loose, broken or missing restorations (fillings)			
Taking any forms of fluoride			
Suffered injuries to your face, mouth, teeth or chin			

Medical History	Yes	No
Abnormal bleeding		
ADD/ ADHD		
AIDS/ HIV+		
Any operation		
Artificial Joints/ Valves		
Asthma		
Cancer		
Congenital Heart Disorder		
Convulsions		
Diabetes		
Epilepsy		
Handicaps/ Disabilities		
Heart Murmur		
Hemophilia		
Hepatitis		
Kidney Problems		
Liver Problems		
Mitral Valve Prolapse		
Prosthetics		
Rheumatic Fever		
Scarlet Fever		
Sickle Cell Disease		
Tuberculosis (TB)		

Medical History

Primary Physician _____
 Phone Number () _____
 Last Visit _____
 Current physical health is: Good Fair Poor
 Explain _____
 List current medications _____

 Is pre-med required for dental visits? no yes
 Explain _____
 Allergies to medications: no yes
 Explain _____
 Other allergies: yes no latex metals nickel plastic
 other _____

Authorization

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform Segal and Iyer Orthodontics of changes in my child's or my own medical status. I authorize the orthodontic staff to perform the necessary dental and/or orthodontic services on my child (if applicable) or myself as needed.

 Patient Signature

 Date