SULLIVAN ORTHODONTICS
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Board Certified Orthodontist

PATIENT INFORMATION - ADULT

ALL ABOUT YOU

PATIENT'S NAME_____ I PREFER TO BE CALLED _____
LAST FIRST MI

RESIDENCE _____
STREET CITY ZIP

HOME PHONE _____ EMAIL _____

CELL PHONE_____ BIRTHDATE_____ SOCIAL SECURITY #_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED

EMPLOYER_____ HOW LONG?_____ TITLE: _____

WORK ADDRESS _____WORK PHONE_____
STREET CITY ZIP

DO YOU PREFER EMAIL OR TEXT MESSAGE REMINDERS FOR UPCOMING APPOINTMENTS?: ☐EMAIL ☐TEXT MSG

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

EMERGENCY CONTACT _____ PHONE _____

OTHER CONTACT INFORMATION

HIS/HER NAME _____ RELATION _____

EMPLOYER _____ PHONE _____

DENTAL HISTORY

GENERAL DENTIST_____ DATE OF LAST VISIT _____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?_____

_____

☐HAVE YOU EVER BEEN EVALUATED FOR ORTHODONTIC TREATMENT?
☐HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM WITH ANY PREVIOUS DENTAL WORK?
☐HAVE YOU EVER LOST OR CHIPPED ANY TEETH?
☐DO YOU LIKE YOUR SMILE?
☐DO YOUR GUMS EVER BLEED?
☐HAVE YOU EVER HAD AN INJURY TO YOUR: MOUTH/TEETH/CHIN?
☐DO YOU HAVE ANY MISSING OR EXTRA PERMANENT TEETH?
☐ARE YOU A MOUTH BREATHER?
☐HAS ANYONE IN YOUR FAMILY RECEIVED ORTHODONTIC TREATMENT?
HOW DID THEY FEEL ABOUT THE RESULT?_____

_____

☐DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN OR DISCOMFORT IN YOUR JAW JOINT (TMJ)?
☐ARE YOU AWARE THAT SOME APPOINTMENTS WILL BE DURING WORK HOURS?

YOUR CURRENT DENTAL HEALTH IS: ☐GOOD ☐FAIR ☐POOR

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes ☐ No ☐ Are you taking any prescription/otc medications? _____
Yes ☐ No ☐ Are you allergic to any medications/Materials? _____
Yes ☐ No ☐ Do you have a history of a major illness? _____
Yes ☐ No ☐ Have you had any operations? _____
Yes ☐ No ☐ Have you ever been involved in a serious accident? _____
Yes ☐ No ☐ Have you ever smoked or chewed tobacco? _____
Yes ☐ No ☐ Have seen a physician in the last 12 months? Why? _____
Yes ☐ No ☐ Are you pregnant? _____

Your current medical condition is: ☐ Good ☐ Fair ☐ Poor

Circle any of the medical conditions below that you have had or currently have:

☐ Abnormal bleeding	☐ Depression/Anxiety	☐ Hepatitis	☐ Pneumonia
☐ Add/Adhd	☐ Diabetes	☐ Herpes/Fever Blisters	☐ Psychiatric Problems
☐ Anemia	☐ Difficulty Breathing	☐ High/Low Blood Pressure	☐ Radiation/Chemotherapy
☐ Arthritis	☐ Dizziness	☐ HIV / Aids	☐ Rheumatic Fever
☐ Artificial Bones/Joints	☐ Epilepsy	☐ Kidney problems	☐ Sinus Problems
☐ Asthma or Hayfever	☐ GI Disorders	☐ Migraines/Headaches	☐ Tuberculosis
☐ Bone Disorders	☐ Heart Problems	☐ Mitral Valve Prolapse	☐ Tumor or Cancer
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Nervous Disorders	

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

_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ D.O.B. _____ Insured's SS#/ID# _____

Insurance Company_____ Group No._____ Plan No._____

Insurance Co Phone No._____ Employer _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ D.O.B. _____ Insured's SS#/ID# _____

Insurance Company_____ Group No._____ Plan No._____

Insurance Co Phone No._____ Employer _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. *In addition, I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

Signature: _____ Date: _____