



DYER & ROBINSON
Orthodontics

ADULT ORTHODONTIC PATIENT INFORMATION

Date _____

Patient's Name _____ Preferred Name _____

Male ___ Female ___ Age ___ Birthdate _____ Phone _____
Month Day Year

Address _____
Street City State Zip

E-mail Address _____

___ Single ___ Married ___ Divorced ___ Children(names & ages) _____

Employed by _____ Occupation _____ No. of Yrs _____

Spouse's Name _____ Spouse's Employer _____

No of Yrs. Employed _____ Occupation _____ Work phone _____

General Dentist _____ Family Physician _____

How did you hear about our office? _____

Do you have any relatives that were treated here? _____

Main reason(s) for seeking orthodontic treatment _____

Patient's hobby or special interest _____

NAME OF RESPONSIBLE PARTY FOR ACCOUNT _____

Relationship to the patient _____

Address _____
Street City State Zip

No. of years at this address? _____ Previous address (if less than 3 yrs.) _____

Work phone _____ Social Security # _____

Employed by _____ Occupation _____ No. of Yrs _____

Is the patient covered by orthodontic insurance? _____ Primary insured's DOB _____

Primary Insurance Co. _____ Policy No. _____

Insurance Co. telephone _____

Secondary Insurance Co. _____ Policy No. _____

Insurance Co. telephone _____

Medical History

- Are you in good health? **Yes No** Explain: _____
- Do you have any major or unusual illnesses? **Yes No** Explain: _____
- Are you currently under the care of a physician? **Yes No** Reason: _____
- Do you have any allergies? **Yes No** List: _____
- Do you have any drug sensitivities? **Yes No** List: _____
- Please list all medications that you are taking and the reason(s) for taking them _____
-

Please indicate if you have or have ever had any of the following:

- | Yes | No | Yes | No | Yes | No |
|-----|-----|-----|-----|-----|-----|
| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |
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| ___ | ___ | ___ | ___ | ___ | ___ |
| ___ | ___ | ___ | ___ | ___ | ___ |

Dental History

- Yes No**
- ___ ___ Does you see a dentist regularly?
- ___ ___ Have you had any severe head or facial injuries? Explain: _____
- ___ ___ Have you consulted with an orthodontist previously?
- ___ ___ Have you had any previous orthodontic treatment? Explain: _____
- ___ ___ Do you Smoke? How much per day _____ How many years _____
- ___ ___ Have you taken or do you take bisphosphonates (osteoporosis medication)

Please check if there is a history of:

- ___ Jaw joint popping ___ Jaw joint clicking ___ Jaw joint pain/soreness ___ Frequent headaches
- ___ Grinding teeth ___ Clenching teeth ___ Ringing in the ears ___ Head or neck muscle soreness

Is there any other info about you that may be important for us to know? _____

Who may we thank for referring you to our office? _____

Signed: _____ Date: _____

TO BE FILLED OUT BY DOCTOR

TMJ: R _____ L _____

Gingiva _____ Habits _____

Hygiene _____ Fractures _____ Heredity _____

Lower Arch _____

Upper Arch _____

Class: Molar R _____ L _____ Cuspid R _____ L _____ Missing _____

X-BITE _____ Slide _____

OB _____ OJ _____ Profile _____ Smile Line _____

Problems _____

Probable : Ext _____ Non Ext _____ Borderline _____ TR. ATT +/-

Treatment Time: _____ Fee Range _____

Comments: _____

NT _____ Charge _____ PD _____