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**ADULT PATIENT INFORMATION**

Date

Patient’s name (last) (First) (Middle)

Address (Street) (City) (Zip)

Nickname Birth date / / Social Security #

**Whom may we thank for referring you to our office?**

**RESPONSIBLE PARTY INFRORMATION**

Name (Last) (First) (Middle)

Residence (Street) (City) (Zip)

Mailing Address (Street) (City) (Zip)

Home Phone Work Phone Cell

Email Address Social Security #

Birth date / / Relationship to Patient

Employer Occupation

**EMERGENCY INFORMATION**

Name of nearest relative not living with you

Complete address (Street) (City) (Zip) Phone

Signature Date

**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 medications?

Yes No Are you allergic to any medications?

Yes No History of major illness?

Yes No Have you had any operations?

Yes No Ever been involved in a serious accident?

Yes No Have you seen a physician in the last 12 months? Why?

Female patients only:

Yes No Are you pregnant?

Circle any of the medical conditions below that the patient has had or currently has.

-Abnormal bleeding/Hemophilia - Diabetes -Hepatitis/Liver problems - Pneumonia

- Anemia -Dizziness -Herpes -Prolonged bleeding

-Arthritis - Epilepsy -High Blood Pressure -Radiation/Chemotherapy

-Asthma or Hay fever - Gastrointestinal Disorder -HIV/Aids -Rheumatic fever

-Bone disorders - Heart Problems -Kidney Problems -Tuberculosis

-Congenital heart defect -Heart Murmur -Nervous Disorders -Tumor or Cancer

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

**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 and my name 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 Dr. Karayiannis to perform a complete orthodontic evaluation.

Signature Date / /

**DENTAL HISTORY**

General Dentist Date of last visit

What concerns you most about your teeth?

Yes No Are you presently in any dental pain?

Yes No Ever experienced any unfavorable reaction to dentistry?

Yes No Have you ever lost or chipped any teeth?

Yes No Has there been any injuries to face, mouth, or teeth?

Yes No Do gums bleed when brushing?

Yes No Any type of thumb or tongue habit?

Yes No Are you a mouth breather?

Yes No Have you seen an orthodontist? If Yes, who and when?

Yes No Has anyone in your family received orthodontic treatment?

Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?

Yes No Experience jaw clicking or popping?

Yes No Aware of clenching or grinding teeth during the day?

Yes No Experience “tension” headaches?

Yes No Are you sensitive or self-conscious about your teeth?