FOOTHILL ORTHODONTICS
Adult Patient Data

Date ______________________

Name ____
First Initial Last DOB Age Sex

Address ________________________________ City_______________ Zip_________

Home Phone____________________ Cell________________ Work_______________

Whome may we thank for referring you to us?___________________________________

Dentist___________________________ Physician_____________________________

Your Occupation__________________ Employer_________________ How Long______

Spouse's Name_________________________________ Birthdate_________________

Occupation_____________________ Employer________________ Phone____________

Marital Status ___________ Children____

Have you ever undergone ortho treatment? If so, when?____________________________

Dental Insurance Data

Your Insurance Co. ______________________________ PPO/HMO/Premier__________

Your SS#____________________ Phone___________________________

______________________________ Cov Amt____________ Mo/Qtr/SAnnual__________
Group Name Group #

Spouse's Insurance Co. __________________________ PPO/HMO/Premier__________

SS#_______________________ Phone___________________________

______________________________ Cov Amt____________ Mo/Qtr/SAnnual__________
Group Name Group #

Medical and Dental History

Are you in good health?__________________________ Yes No

Date of last physical exam____________ Date of last dental check-up____________

Are you under the care of a physician?__________________________ Yes No

If so, for what reason?__________________________

If taking any drugs or medications, please list__________________________

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Are you sensitive or allergic to any drugs, latex or metals?______________ Yes No

If so, please list__________________________

Do you have or have you had any of the following:

____Anemia	____Cold Sores	____Drug Addiction	____Respiratory Disease
____Allergies	____Asthma	____Kidney Disease	____High Blood Pressure
____AIDS	____Strep	____Mental Disorder	____Epilepsy or Seizures
____Diabetes	____Hay Fever	____Rheumatic Fever	____Excessive Bleeding
____Arthritis	____Head Injury	____Thyroid Disease	____Fainting or Dizziness
____Liver Disease	____Scarlet Fever	____Blood Transfusion	____Radiation Treatment
____ Sinus Infection	____Blood Disease	____Venereal Disease	____Jaw Joint Problems

If there is another condition, please describe__________________________

Have you had any injuries to your head or face?______________________ Yes No

(Women) Are you pregnant?__________________________ Yes No

Have you consulted another orthodontist?_____ If so, who?______________

What is your primary reason for coming to our office?______________

What would you like for us to do for you?__________________________

What is your feeling about wearing braces?__________________________

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist and his staff to determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the orthodontist and his staff.

I further acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES.

Signature__________________________ Date____________