Greg Carr DMD, MS

Specialist in Orthodontics

NEW PATIENT INFORMATION – ADULT

Please fill out this form as completely as you can. The better we communicate, the better we can care for you.

Date _____

Name _____ *I prefer to be called* _____ *Sex* □ *M* □ *F*

Address _____ *City* _____ *Zip*_____

Cell # _____ *Home #* _____

Age _____ *Birth date* _____ *Other family members seen by us* _____

Who may we thank for referring you? _____

Main orthodontic concern(s) _____

BILLING PARTY INFORMATION

Name _____ *Relationship to Patient*_____

Address _____ *City* _____ *State*_____ *Zip*_____

Cell # _____ *Home #* _____ *Email* _____

Marital Status □ *Single* □ *Married* □ *Divorced* □ *Widowed* *Birth date* _____ *SSN* _____

*Employed by*_____ *How long?* _____ *Occupation* _____

Spouse's Name _____ *Birth date* _____ *SSN* _____

*Employed by*_____ *How long?* _____ *Occupation* _____

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____ *Insured's Birth date* _____

*Insured's SSN/ID#*_____ *Insured's Employer* _____

Insurance Company _____ *Group #* _____*Effective Date* _____

Phone # _____ *Do you have orthodontic coverage?* □*Yes* □*No*

Secondary Insured's Name _____ *Insured's Birth date*_____

Insured's SSN/ID# _____ *Insured's Employer* _____

Insurance Company _____ *Group #* _____ *Effective Date* _____

Phone # _____ *Do you have orthodontic coverage?* □*Yes* □*No*

(CONTINUED ON REVERSE SIDE)

MEDICAL & DENTAL HISTORY

Dentist's Name _____ *Month/Year of last check-up* _____

Please describe your health: ☐***Good*** ☐***Fair*** ☐***Poor***. *Currently under care of a physician?* ☐ ***Yes*** ☐ ***No*** *Reason:* _____

Do you take any medications? ☐ ***Yes*** ☐ ***No***

*Please list all medications taken:*_____

Allergy or adverse reaction to any medications? _____

Allergy to latex, metal or any dental/medical products? ☐ ***Yes*** ☐ ***No*** _____

Require antibiotic pre-medication for any heart condition when seeing the dentist? ☐ ***Yes*** ☐ ***No***

Ever taken any Bisphosphonate medication (ex: Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa)? ☐ ***Yes*** ☐ ***No***

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

☐ ***Yes*** ☐ ***No*** *Abnormal Bleeding*
☐ ***Yes*** ☐ ***No*** *Adenoids/Tonsils removed*
☐ ***Yes*** ☐ ***No*** *Allergies/Sinus Trouble*
☐ ***Yes*** ☐ ***No*** *Anemia*
☐ ***Yes*** ☐ ***No*** *Asthma*
☐ ***Yes*** ☐ ***No*** *Arthritis*
☐ ***Yes*** ☐ ***No*** *Bone Disorders*
☐ ***Yes*** ☐ ***No*** *Cancer*
☐ ***Yes*** ☐ ***No*** *Congenital Heart Defect*
☐ ***Yes*** ☐ ***No*** *Convulsions/Epilepsy*
☐ ***Yes*** ☐ ***No*** *Diabetes*
☐ ***Yes*** ☐ ***No*** *Heart Murmur*
☐ ***Yes*** ☐ ***No*** *Hepatitis*
☐ ***Yes*** ☐ ***No*** *HIV/AIDS*
☐ ***Yes*** ☐ ***No*** *Rheumatic fever/Scarlet fever*
☐ ***Yes*** ☐ ***No*** *Kidney/Liver Problems*
☐ ***Yes*** ☐ ***No*** *Tuberculosis*
☐ ***Yes*** ☐ ***No*** *Hearing impairment*
☐ ***Yes*** ☐ ***No*** *Handicaps/Disabilities*
☐ ***Yes*** ☐ ***No*** *Prosthesis*
☐ ***Yes*** ☐ ***No*** *Operations/Stays in Hospital*

Any other disease, condition or problem not listed above? _____

_____

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ ***Yes*** ☐ ***No***
Have you ever had a serious/difficult problem associated with dental work? ☐ ***Yes*** ☐ ***No***
Have there ever been any injuries to the face, mouth or teeth? ☐ ***Yes*** ☐ ***No***
Have you been informed of any missing or extra permanent teeth? ☐ ***Yes*** ☐ ***No***

Do you have any speech problems or difficulties? ☐ ***Yes*** ☐ ***No***
History of Thumb/Finger sucking ☐ ***Yes*** ☐ ***No***
Tongue Thrusting ☐ ***Yes*** ☐ ***No***
Lip sucking/biting ☐ ***Yes*** ☐ ***No***
Nail biting ☐ ***Yes*** ☐ ***No***
Strong tendency for mouth breathing? ☐ ***Yes*** ☐ ***No***
Have you consulted an orthodontist previously? ☐ ***Yes*** ☐ ***No***
Are there any other family members with similar orthodontic conditions? ☐ *Father* ☐ *Mother* ☐ *Brother/Sister* ☐ *Other*

Authorizations

The information on this questionnaire is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

I authorize my insurance company or companies to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize this office to submit insurance claims on my behalf. I understand that I am financially responsible for any difference between estimated insurance benefits the actual benefits.

Print Name _____

Signature _____ *Date*_____

OFFICE USE ONLY – OFFICE USE ONLY – OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian/patient named herein.

Initials _____ Date _____ Comments _____

Update: Initials _____ Date _____ Comments _____
Initials _____ Date _____ Comments _____
Initials _____ Date _____ Comments _____