

Bowles Orthodontic Specialists, P.A.



ADULT ORTHODONTIC CONSULTATION

We will appreciate your providing the information requested below.

Date of Birth _____ Age _____
(month) (day) (year)

Patient's Name _____ Male _____ Female _____

Residence Street Address _____

City _____ State _____ Zip _____ Phone _____

Patient's Dentist _____ Last Visit _____

Patient's Physician _____ Last Visit _____

Whom should we thank for referring you to our office? _____

Has anyone else in your family been treated in this office? _____

Has another orthodontist been consulted previously? _____

In your own words, what is the problem? _____

FINANCIAL INFORMATION

Person Responsible for Account _____

Address _____

SSN _____ Home Phone _____ Bus. Phone _____

Employer _____ Occupation _____

Relationship to Patient _____

Marital Status (Please Circle) Single Married Separated Divorced Widowed

INSURANCE INFORMATION

Do you have insurance coverage which includes orthodontic treatment for adults _____yes _____no If yes, please list:

Insurance Name _____ Insurance Subscriber's Name _____

Subscriber's Member # or SSN _____ Subscriber's Birthdate _____

Subscriber's Employer _____ Relationship to Patient _____

SIGNED _____ DATE _____

For all accounts requesting financing in our office, an additional credit check signature is required here: _____

MEDICAL HISTORY (Circle Answer)

- 1. Are you in good health?..... Yes No
- 2. Has there been any change in your general health within the past year?..... Yes No
- 3. Are you now under the care of a physician?..... Yes No
If so, what is the condition being treated? _____
- 4. Have you had any serious illness, operation, or been hospitalized in the past year?..... Yes No
If so, what was the illness or problem? _____
- 5. Are you taking any medicine(s) including non-prescription medicine?..... Yes No
If so, what medicines(s) are you taking? _____
- 6. Do you have or have you had any of the following diseases or problems?
 - a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease..... Yes No
 - b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
 - c. Allergy..... Yes No
 - d. Sinus trouble..... Yes No
 - e. Asthma or hay fever..... Yes No
 - f. Fainting spells or seizures..... Yes No
 - g. Persistent diarrhea or recent weight loss..... Yes No
 - h. Diabetes..... Yes No
 - i. Hepatitis, jaundice or liver disease..... Yes No
 - j. AIDS or HIV infection..... Yes No
 - k. Thyroid problems..... Yes No
 - l. Respiratory problems, emphysema, bronchitis, etc..... Yes No
 - m. Arthritis or painful swollen joints..... Yes No
 - n. Stomach ulcer or hyperacidity..... Yes No
 - o. Kidney trouble..... Yes No
 - p. Tuberculosis..... Yes No
 - q. Sexually transmitted disease..... Yes No
 - r. Epilepsy or other neurological disease..... Yes No
 - s. Problems with mental health..... Yes No
 - t. Cancer..... Yes No
 - u. Problems of the immune system..... Yes No
- 7. Have you experienced abnormal bleeding?..... Yes No
If so, have you ever required a blood transfusion?..... Yes No
- 8. Do you have any blood disorder such as anemia?..... Yes No
- 9. Have you ever had any treatment for a tumor or growth?..... Yes No
- 10. Are you patient allergic or ever had a reaction to any medication?..... Yes No
If so, list medications causing the allergic reaction _____
- 11. Have your tonsils and adenoids been removed?..... Yes No

WOMEN

- 12. Are you pregnant?..... Yes No

DENTAL HISTORY (Circle answer)

- 13. Have there been any injuries to the face, mouth, or teeth?..... Yes No
 - 14. Have you ever sucked thumb or fingers? Until what age?..... Yes No
 - 15. Have you ever had any oral habits, such as lip biting or tongue thrusting?..... Yes No
 - 16. Do you have any speech problems?..... Yes No
 - 17. Have you ever had speech therapy?..... Yes No
 - 18. Are you a mouth breather while asleep or awake?..... Yes No
 - 19. Are you aware of any missing or extra permanent teeth?..... Yes No
 - 20. Would you consider your diet high in sweets?..... Yes No
 - 21. Do your gums ever bleed?..... Yes No
 - 22. Do you clench or grind teeth?..... Yes No
 - 23. Are your teeth sore or sensitive?..... Yes No
 - 24. Have your teeth seemed to shift or move recently?..... Yes No
 - 25. Does your jaw make a popping or grinding noise?..... Yes No
 - 26. Has your jaw ever locked or slipped out of place?..... Yes No
 - 27. Do you often have Headaches Earaches Jaw Joint Pain Neck Pain..... Yes No
- Chief Dental Complaint _____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient