Today's Date _____

PLEASE PRINT CLEARLY

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Adult Patient Information

PATIENT: Name (FIRST / MIDDLE INITIAL / LAST)		Nickname	Birthdate / AGE	Sex
Home Address	City	Zip	Home Phone	
Employer		Occupation		
Employer's Address	City	Zip	Work Phone	
Other family members seen in our office		Referred by		
SPOUSE: Name				
Employer		Occupation		
Employer's Address	City	Zip	Work Phone	

Insurance Information

PRIMARY INSURANCE: Insured Member		Social Security No.	Birthdate
Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Employer		Group No.	
SECONDARY INSURANCE: Insured Member		Social Security No.	Birthdate
Secondary Insurance Company		Phone	
Address	City	State	Zip
Insured's Employer		Group No.	

I accept responsibility for payment of all costs incurred with Zammitti Orthodontics. I understand that, where appropriate, Credit Bureau reports may be obtained

Signature of Responsible Party Date

Dental History

Patient's Dentist	City	Phone
Primary Concern	Date of last cleaning	

1. Has there been previous orthodontic treatment? ☐ Yes ☐ No If yes, by whom?
2. Is there or has there been a concern about periodontal (gum and bone) problems? ☐ Yes ☐ No
3. Is there any UNUSUAL dental history? ☐ Yes ☐ No If yes, please explain:
4. Have any teeth been bumped or injured? ☐ Yes ☐ No If yes, please explain:
5. Is there a tendency to gag easily ☐ Yes ☐ No
6. Do any speech problems exist ☐ Yes ☐ No
7. Have you ever HAD or PRESENTLY HAVE any of the following habits:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Thumb sucking	☐	☐	Lip biting	☐	☐	Grinding or clenching teeth	☐	☐	Other:
☐	☐	Finger sucking	☐	☐	Nail biting	☐	☐	Snoring			
☐	☐	Tongue thrusting	☐	☐	Mouth breathing	☐	☐	Smoking/Tobacco Chewing			

If yes, when did the habit stop?

8. Are you frightened or anxious about orthodontic treatment? ☐ Yes ☐ No
9. Are you concerned about the appearance of your teeth? ☐ Yes ☐ No
10. What aspect of orthodontic treatment are you most concerned about?

☐ Quality ☐ Cost ☐ Discomfort ☐ Length of Treatment

Medical History

Patient's Physician | City | Phone

1. Have you ever HAD or PRESENTLY HAVE any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Tumors	☐	☐	Bleeding Disorders	☐	☐	Headaches
☐	☐	Heart Murmur	☐	☐	Convulsions	☐	☐	Glaucoma	☐	☐	Cleft Lip or Palate
☐	☐	Artificial Heart Valve / Pacemaker	☐	☐		Epilepsy	☐		☐		Glandular Disorders
☐	☐	Jaw Clicking/Popping									
☐	☐	Mitral Valve Prolapse	☐	☐	Cancer	☐	☐	Genetic Disorders	☐	☐	Jaw Stiffness/Locking
☐	☐	High/Low Blood Pressure	☐	☐	Sleep Disorders	☐	☐	Kidney Disorders	☐	☐	Jaw Soreness
☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐	Breathing Disorders	☐	☐	Other:
☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Fainting / Dizziness			
☐	☐	Arthritis	☐	☐	HIV / AIDS	☐	☐	Emotional Problems			

2. Is your general health good at this time? ☐ Yes ☐ No

3. Are you under the care of a physician at this time? ☐ Yes ☐ No If yes, please explain:

4. Are you taking any medication(s) at this time? ☐ Yes ☐ No Name of medication(s):

5. Are you allergic to any medication(s)? ☐ Yes ☐ No Name of medication(s):

6. Do you have a latex allergy? ☐ Yes ☐ No

7. Do you have a metal allergy? ☐ Yes ☐ No

8. Have you had tonsils and/or adenoids removed? ☐ Yes ☐ No

9. Have you had a serious illness or been hospitalized? ☐ Yes ☐ No If yes, please explain:

10. Have you ever been advised by your physician to take an antibiotic prior to any dental procedures ☐ Yes ☐ No
If yes, antibiotic name and method:

11 Have you ever had a severe head or facial injury? ☐ Yes ☐ No If yes, please explain:

12. Have you ever taken any prescribed diet medication(s)? ☐ Yes ☐ No Name of medication(s):

13. Do you have any disease, condition, or problems not listed? ☐ Yes ☐ No
If yes, please explain:

Please use space below to provide any helpful information. Feel free to include any questions you may have:

Member
American Association of
Orthodontists

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct.
THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.
I grant authority to Zammitti Orthodontics to perform all procedures and treatments in the patient's best interest.

Signature of Patient **Date**