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Email us at info@BracesOnline.com
Text us at 508.485.8788

CARVALHO & ROTH
ORTHODONTICS
www.BracesOnLine.com

Adult Patient Information

PATIENT: NAME		Nickname	Birthdate	Sex
Home Address	City	Zip	Home Phone	
Employer		Occupation		
Employer Address		City	Zip	Work Phone
Other Family Members seen in our office		Referred by		
Spouse: Name				
Employer		Occupation		
Employer Address	City	Zip	Work Phone	

Insurance Information

PRIMARY INSURANCE: Subscriber			Birthdate
Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Employer		Group No	
SECONDARY INSURANCE:Subscriber		Birthdate	
Secondary Insurance Company		Phone	
Address	City	State	Zip
Insured's Employer		Group No	
I accept responsibility for payment of all costs incurred with Carvalho & Roth 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	
Has there been previous orthodontic treatment?	▢ Yes ▢ No	If yes, by whom?
Is there or has there been a concern about periodontal (gum and bone) problem?	▢ Yes ▢ No	
Is there any UNUSUAL dental history?	▢ Yes ▢ No	If yes, please explain
Have any teeth been bumped or injured?	▢ Yes ▢ No	If yes, please explain
Is there a tendency to gag easily?	▢ Yes ▢ No	
Do any speech problems exist?	▢ Yes ▢ No	

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?

Dental History

Are you frightened or anxious about orthodontic treatment?	▢ Yes ▢ No
Are you concerned about the appearance of your teeth?	▢ Yes ▢ No

What aspect of orthodontic treatment concerns you?

▢ Quality	▢ Cost	▢ Discomfort	▢ Length of Treatment

Medical History

Patient's Physician		City	Phone

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

Is your general health good at this time?	▢ Yes	▢ No	
Are you under the care of a physician at this time?	▢ Yes	▢ No	If yes, please explain.
Are you taking medication(s) at this time?	▢ Yes	▢ No	Name of medication(s):
Are you allergic to any medication(s)?	▢ Yes	▢ No	Name of medication(s):
Do you have a latex allergy?	▢ Yes	▢ No	
Do you have a metal allergy?	▢ Yes	▢ No	
Have you had your tonsils and/or adenoids removed?	▢ Yes	▢ No	
Have you had a serious illness or been hospitalized?	▢ Yes	▢ No	If yes, please explain.
Are you required to take antibiotic prophylaxis prior to dental treatment?	▢ Yes	▢ No	If yes, why and what medication?
Have you had a severe head or facial injury?	▢ Yes	▢ No	If yes, please explain.
Have you ever taken any prescribed diet medication(s)?	▢ Yes	▢ No	Name of medication(s):
Do you have any disease, condition, or problem not listed?	▢ Yes	▢ No	If yes, please explain.

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

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 THE INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to Carvalho & Roth Orthodontics to perform all procedures and treatments in the patient's best interest.

Signature of Patient Date

Member American Association of Orthodontists