PREMIER Orthodontics

PATIENT HISTORY - ADULT

Name____ Male / Female
Last Name First Name Initial Mr. Mrs. Ms. Dr.

Address ____

City ________________ State ________ Zip __________ Email ________________

Home Ph# ________________ Cell Ph# ________________ Cell Carrier________________

Birthdate _____/_____/_____ Age ________ Marital Status (if applies) Single Married Divorced

Whom may we thank for referring you? ________________________________

PRIMARY RESPONSIBLE PARTY

Person Responsible for Account ________________________________
Last Name First Name Initial Marital Status

Relation to Patient ________________ Birthdate_____/_____/_____ Soc. Sec. #________________

Address (**if different from above**)________________________________

Cell #________________ Cell Carrier ________________ Email________________

Employer________________________________ Occupation ________________

Business Address ________________________________ Business Ph# ________________

Insurance Company________________________________ Phone #________________

Subscriber ID#________________________________ Group/Policy # ________________

SECONDARY RESPONSIBLE PARTY

Person Responsible for Account ________________________________
Last Name First Name Initial Marital Status

Relation to Patient ________________ Birthdate_____/_____/_____ Soc. Sec. #________________

Address (**if different from above**)________________________________

Cell #________________ Cell Carrier ________________ Email________________

Employer________________________________ Occupation ________________

Business Address ________________________________ Business Ph# ________________

Insurance Company________________________________ Phone #________________

Subscriber ID#________________________________ Group/Policy # ________________

Please complete both sides

DENTAL HISTORY

Dentist ____ Date of Last Dental Exam _____________________

Circle (Yes / No) if you have had problems with any of the following:

Bad Breath	Yes / No	Bleeding gums	Yes / No	Clicking, popping, locking of jaw	Yes / No
Sensitivity to cold	Yes / No	Sensitivity to hot	Yes / No	Food collecting between teeth	Yes / No
Sensitivity to sweets	Yes / No	Periodontal treatment	Yes / No	Grinding/clenching teeth	Yes / No
Sores in mouth	Yes / No	Loose/Broken teeth	Yes / No	Thumb/finger sucking	Yes / No
Mouth breathing	Yes / No	Snoring	Yes / No	Nail biting	Yes / No

Any injuries to mouth Yes / No If yes please explain ____

Have you ever been evaluated for orthodontic treatment? Yes / No Orthodontist________________________________

MEDICAL HISTORY

Physician's Name ____ Phone # _________________________________

Any recent illness(or)surgeries Yes / No If yes describe____

Are you currently under physician care Yes / No If yes, describe ____

Do you still have: Tonsils Yes / No Adenoids Yes / No

For Women: Are you pregnant? Yes / No Taking birth control pills Yes / No

Circle (Y: Yes or N: No) whether you have (or) had any of the following:

AIDS/HIV+	Y / N	Hepatitis	Y / N	High Blood pressure	Y / N	Stroke	Y / N
Anaphylaxis	Y / N	Diabetes	Y / N	Epilepsy	Y / N	Asthma	Y / N
Fainting	Y / N	Hemophillia	Y / N	Cancer	Y / N	Heart attack	Y / N
Sinus Prob.	Y / N	Heart Murmur	Y / N	Congenital Heart Def.	Y / N	Jaw Pain	Y / N
Headaches	Y / N	Kidney Disease	Y / N	Liver Disease	Y/ N	Tuberculosis	Y / N
Cold Sores	Y / N	Drug/Alcohol abuse	Y / N	Mitral Valve Prolapse	Y / N	Rheum Fever	Y / N

Are you taking any medication for your bones? Yes / No If yes, List_______________________________________
Are you currently taking any medications? Yes / No If Yes, List____
Do you have any drug allergies? If Yes, List all: ____

Allergic to LATEX YES / NO

I understand the information that I have given is correct to the best of my knowledge, 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 also authorize the orthodontic staff to perform the necessary orthodontic services I may need.

I authorize OrthoBanc LLC, on behalf of Dr. Dustin Coles, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

I have also read, understand and have been offered a copy of the HIPPA consent form.

____ ______________________________

Signature **Date**