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## WELCOME TO OUR OFFICE

### ADULT PATIENT INFORMATION

Name: \_\_\_\_\_ Prefer to be called: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_

E-mail: \_\_\_\_\_ Dentist's Name: \_\_\_\_\_

Do you know a patient currently in our practice? If so, whom: \_\_\_\_\_

Who noticed your orthodontic problem?  You  Dentist  Other \_\_\_\_\_

Describe your orthodontic problem in your own words: \_\_\_\_\_

What concerns you most about orthodontic treatment?

Appearance in appliances  cost  length of time  discomfort  results  other \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_ Wk. Phone \_\_\_\_\_

How long with this employer? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Family And Account Information

Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk phone: \_\_\_\_\_ Person  
responsible for account: \_\_\_\_\_

*If other than self or spouse:*

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of an emergency, please provide name, address and phone number of your nearest relative:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

I authorize Cunningham Orthodontics, P.C. to accept assignments on all insurance benefits. If we do not accept assignment from your insurance provider, we will gladly assist you in submitting your claim forms regarding any charge for care in our office.

**Billing Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Name of insured (Employee): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

**Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.**

**MEDICAL HISTORY**

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- Have you ever experienced any health problems?  No  Yes Explain: \_\_\_\_\_
- Any major change in your health recently?  No  Yes Explain: \_\_\_\_\_
- Are you currently under a physician's care?  No  Yes Explain: \_\_\_\_\_
- Are you currently taking any medications?  No  Yes List: \_\_\_\_\_
- Are you allergic to any medications?  No  Yes List: \_\_\_\_\_
- Have you received a blood transfusion?  No  Yes Reason: \_\_\_\_\_
- Have your tonsils or adenoids been removed?  No  Yes When: \_\_\_\_\_

Please check if you have had any of the following conditions:

- |   |   |   |
|---|---|---|
| Heart Murmur/Surgery... <input type="checkbox"/> No <input type="checkbox"/> Yes  | Hepatitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes     | Emotional Problems.... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| AIDS..... <input type="checkbox"/> No <input type="checkbox"/> Yes                | Diabetes..... <input type="checkbox"/> No <input type="checkbox"/> Yes      | Frequent Headaches.... <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic Fever..... <input type="checkbox"/> No <input type="checkbox"/> Yes     | Kidney Disease... <input type="checkbox"/> No <input type="checkbox"/> Yes  | Nervous/Anxious..... <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| Endocrine disorders..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Disease..... <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer..... <input type="checkbox"/> No <input type="checkbox"/> Yes            |
| Prolonged Bleeding..... <input type="checkbox"/> No <input type="checkbox"/> Yes  | Tuberculosis..... <input type="checkbox"/> No <input type="checkbox"/> Yes  | Bone Disorders..... <input type="checkbox"/> No <input type="checkbox"/> Yes    |
| Anemia..... <input type="checkbox"/> No <input type="checkbox"/> Yes              | Bronchitis..... <input type="checkbox"/> No <input type="checkbox"/> Yes    | Growth Disorders..... <input type="checkbox"/> No <input type="checkbox"/> Yes  |

Name: \_\_\_\_\_

Is there any other condition or problem that you think we should know about? \_\_\_\_\_

**DENTAL HISTORY**

Dentist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Specialist's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental checkups:  2 times a year  1 time a year  Only if problem exists  Never Date of Last Visit: \_\_\_\_\_

Name: \_\_\_\_\_

- Is there any unfinished care to be completed with your dentist?  No  Yes Explain: \_\_\_\_\_
- Are you frightened about dental treatment?  No  Yes Explain: \_\_\_\_\_
- Have you had an unpleasant experience in the dental office?  No  Yes Explain: \_\_\_\_\_
- Have you had any facial or dental injuries?  No  Yes Explain: \_\_\_\_\_
- Do you play any musical instruments?  No  Yes What instrument: \_\_\_\_\_
- Have you consulted an orthodontist previously?  No  Yes With whom: \_\_\_\_\_
- Have teeth (either primary or permanent) been removed?  No  Yes
- Have you had any previous orthodontic treatment?  No  Yes With whom: \_\_\_\_\_
- Are you satisfied with prior treatment?  No  Yes Explain: \_\_\_\_\_
- Any changes in your bite or dental alignment recently?  No  Yes Explain: \_\_\_\_\_

Please check if there is a history of:

- Clenching teeth  Muscular Soreness around head & neck  Jaw joint soreness  Jaw joint popping
- Grinding teeth  Headaches (more than normal)  Jaw joint clicking  Ringing in the ears
- Speech problems (if so what sounds \_\_\_\_\_)  Mouthbreathing Awake \_\_\_\_\_ Asleep \_\_\_\_\_

Is there any other information which may be helpful? \_\_\_\_\_

**I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial report.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Reviewed by**

\_\_\_\_\_  
**Date**