Welcome to Boss Orthodontics!
Adult Orthodontic Information

Date: ____________________

Name:____ I prefer to be called:__________________

Address:__________________________________City:_________________State:_____Zip:_________

Home#____________________ Cell#______________________ Work #_______________________

D.O.B:_________________ Soc. Sec. #:____________________ E-Mail:___________________________

Staus: ______Single _________Married _______Divorced ______Widowed _______Separated

Employer: ________________________________Address:____

Other family members seen by us: ____
General Dentist: _______________________________________
Approximate date of last visit to general dentist: __________________
How did you hear about our office?_____________________________

Spouse Information
His/Her Name: ____
Home#_______________________ Cell#_________________________
Work#_________________________Ext.:_____
Employer: ____
Address:_____________________________Soc.Sec#__________________

In the event of an emergency, is there someone that lives near you that we should contact?
His/Her Name: ____ Relation__________________
Home#_____________________ Cell#__________________________Work#____________________

Person Responsible for Account
Name:______________________________________Relationship:_____________________
Billing Address:____
Home#____________________Cell#________________________

Primary Orthodontic Insurance
Insurance Company Name: ____
Insurance Company Address: ____
Insurance Company Phone #:____
Insured's Name: ____________________________ Relationship to Patient: _______________
Group/Policy#:________________________ Insured's D.O.B.______________________
Insurance ID#:____________________ Insured's Employer:_________________________

Secondary Orthodontic Insurance
Insurance Company Name: ____
Insurance Company Address: ____
Insurance Company Phone#:____
Insured's Name: ____________________________ Relationship to Patient: __________________
Group/Policy#________________________ __ Insured's D.O.B:_______________________
Insurance ID#_______________________ Insured's Employer: ________________________

Do you like your smile? _______YES_______NO, why not?_______________________________________

Have you ever been evaluated for orthodontic treatment? _______NO_______YES,
when____

Have you ever had a serious/difficult problem associated with any previous dental work?_____NO
________YES Explain:____

Do you now or have you ever experienced pain/discomfort in your jaw joint? _______NO _______YES
Explain:____

Do you like your chin and facial profile (side view)? ______YES ______NO, why not? ____________________

Have you ever been told that you have Gingivitis, Periodontitis, or Periodontal (gum) disease?
_______NO _________YES, when?____

Your current physical health is _________GOOD__________ FAIR _________POOR

Are you currently under the care of a Physician? _________NO _________YES
Please explain: ____

Are you taking any prescription/over the counter drugs? ________NO ________YES
Please list which ones : ____

Are you allergic to Latex, Plastic or any Metals? ______Yes__________No

Please list any drugs you are allergic to: __________________________________

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack/Stroke	Y N Cancer/Chemotherapy	Y N Heart Murmur
Y N Rheumatic Fever	Y N Heart Surgery/Pacemaker	Y N HIV+ /AIDS
Y N Kidney Problems	Y N Mitral Valve Prolapse	Y N Shingles
Y N Artificial Bones/Joints	Y N Artificial Valves	Y N Sinus Problems
Y N High or Low Blood Pressure	Y N Severe/Frequent Headaches	Y N Fever Blisters
Y N Difficulty Breathing	Y N Diabetes/Tuberculosis (TB)	Y N Hepatitis
Y N Congenital Heart Defect	Y N Hemophilia/Abnormal Bleeding	Y N Epilepsy
Y N Hospitalized for Any Reason	Y N Blood Transfusion	Y N Glaucoma

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my health or medical status. Also, this office may verify the credit status of potential patients through a local credit reporting service prior to extending credit for treatment fees.

___________________________________ ___________________________

Signature Date

Date: _________ **Age:**________
Malocclusion: Class ____ Rt____Lft **Overjet**_________**Overbite**_________
Maxillary spacing: slt mod svr **Mandibular spacing**: slt mod svr
Maxillary crowding: slt mod svr **Mandibular crowding**: slt mod svr
Constriction: max mand **Crossbites**:___________________
Notes:____
____
____
____
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