Scott Orthodontic ASSOCIATES

Adult

Date: _____ **Time:** _____

Patient
Name:_____ Nickname: _____ Sex: _____ Age: _____ Birthdate: _____-_____ - _____

Address: _____

_____ Single ☐ Married ☐ Widowed ☐ Divorced ☐

E-Mail: _____ S. S. # _____ - _____ - _____ Home Phone: _____

Occupation: _____ Employer: _____ Work Phone:_____ Ext. _____

Orthodontic Insurance: _____ Orthodontic benefits? _____ Okay to call @ work? Yes ☐ No ☐

Spouse's
Name: _____ **Spouse's** Occupation:_____

Spouse's Employer: _____ S. S. # _____ - _____ - _____

Spouse's Work Phone: _____ Ext. _____ Okay to call @ work? Yes ☐ No ☐

Orthodontic Insurance: _____ Birthdate: _____ S. S. # _____ - _____ - _____

Other
Financially resposible party:_____ Relationship: _____

Home Phone: _____

Address:_____ Work Phone: _____ Ext. _____

Occupation: _____ Employer: _____ Okay to call @ work? Yes ☐ No ☐

Orthodontic Insurance: _____ Birthdate: _____ S. S. # _____ - _____ - _____

Who referred you to us? _____ Family members we have seen:_____

Who is your dentist? _____ Last Cleaning?_____ Months since last panoramic x-ray taken? _____

Have you had orthodontic treatment? Yes ☐ No ☐ If so, who was your doctor? _____ When? _____

Do you *have*, or *have you had* any of the following?

Heart disease?	Yes ☐	No ☐	Epilepsy?	Yes ☐	No ☐	Breathing problems?	Yes ☐	No ☐
Kidney disease?	Yes ☐	No ☐	AIDS?	Yes ☐	No ☐	Current thumb habit?	Yes ☐	No ☐
High blood pressure?	Yes ☐	No ☐	Clicking jaw joints?	Yes ☐	No ☐	Past thumb habit?	Yes ☐	No ☐
Hepatitis?	Yes ☐	No ☐	Frequent headaches?	Yes ☐	No ☐	Gum disease?	Yes ☐	No ☐
Rheumatic fever?	Yes ☐	No ☐	Difficulty chewing?	Yes ☐	No ☐	Osteoporosis Medication?	Yes ☐	No ☐
Allergies _____	Yes ☐	No ☐	Grinding or clenching teeth?	Yes ☐	No ☐	Other: _____		
Heart murmur?	Yes ☐	No ☐	Morning jaw stiffness?	Yes ☐	No ☐	_____		
Diabetes?	Yes ☐	No ☐	Pain in the jaw joints?	Yes ☐	No ☐	_____		
Stroke?	Yes ☐	No ☐	Tonsillectomy?	Yes ☐	No ☐			

Name of Physician: _____ Are you under the care of a doctor? Yes ☐ No ☐

If so, for what? _____

Please list all medication being taken: _____

I the undersigned have given the information, have reviewed it, and find it accurate.

****In signing this, I grant permission for credit approval.****

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE ADULT DATE