Patient Information - Adult

PATIENT NAME:
Date of Birth: Age:
Address: ,
Primary Telephone:

Patient Title: ❒ Dr. ❒ Mrs. ❒ Ms. ❒ Mr. Gender: ❒ Male ❒ Female

Patient's Dentist: _____ City: _____

Whom may we thank for referring you to our office?: _____

How did you hear about us?: ❒ Dentist ❒ Family ❒ Friend ❒ Internet ❒ Print Ad ❒ Yellow Pages ❒ Other

Work Phone: _____ Mobile Phone: _____
Preferred phone: ❒ Home ❒ Work ❒ Mobile

E-mail Address: _____

Employer: _____ Job Title _____

Patient's Insurance Information

Do you have orthodontic coverage? ❒ Yes ❒ No

Subscriber's Name: _____ D.O.B. _____
Title *First* *Last*
Same as Above ❒

Address: _____
Same as Above ❒

Home Phone: _____
Same as Above ❒

Work Phone: _____ Mobile Phone: _____
Preferred phone: ❒ Home ❒ Work ❒ Mobile

Employer: _____ Job Title: _____

Insurance Co. Name & Address: _____

Subscriber ID: _____ Group #: _____

SS#: _____

If the office accepts this insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

Patient's Signature *Date*

**Please make any necessary corrections to autofilled information*

Andrew J. Kuhlberg DMD, MDS
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www.kuhlbergorthodontics.com

Please see reverse

PATIENT NAME: Date of Birth: Address: , Primary Telephone:	*Please make any name/address/phone corrections here:*

***** What are your main orthodontic concerns?

Adult Confidential Medical and Dental History

Have you ever had any of the following conditions?

Abnormal bleeding	❒ Yes ❒ No	Endocrine/Growth disorders	❒ Yes ❒ No
Attention Deficit Disorder/ADHD	❒ Yes ❒ No	Handicaps/Disabilities	❒ Yes ❒ No
Allegies to any drugs	❒ Yes ❒ No	Heart murmur	❒ Yes ❒ No
Allergy to Latex	❒ Yes ❒ No	Hemophilia/Blood disorders	❒ Yes ❒ No
Any hospital stays	❒ Yes ❒ No	Hepatitis	❒ Yes ❒ No
Any operations/surgery	❒ Yes ❒ No	HIV/AIDS	❒ Yes ❒ No
Asthma	❒ Yes ❒ No	Kidney/Liver Problems	❒ Yes ❒ No
Cancer	❒ Yes ❒ No	Nickel Allergy	❒ Yes ❒ No
Chronic Sinus Problems	❒ Yes ❒ No	Rheumatic/Scarlet Fever	❒ Yes ❒ No
Congential heart defect	❒ Yes ❒ No	Tonsils/Adenoids Removed	❒ Yes ❒ No
Convulsions/Epilepsy	❒ Yes ❒ No	Tuberculosis	❒ Yes ❒ No
Diabetes	❒ Yes ❒ No	Other Medical or Health Conditions not listed	*DESCRIBE BELOW*

Do you have osteoporosis, arthritis or any bone disorders? ❒ Yes ❒ No Do you take bisphosphonate medications? ❒ Yes ❒ No
Are you currently under the care of a physician for any medical problems? ❒ Yes ❒ No

Have you ever been told to take an antibiotic medication prior to dental visits? ❒ Yes ❒ No
Please list any drugs/medications that you are taking:

Have you had any of the following treatments?

Restorations/fillings/bonding	❒ Yes ❒ No
Crowns, Caps, or Bridges	❒ Yes ❒ No
Dental Implants	❒ Yes ❒ No
Root Canal Therapy	❒ Yes ❒ No
Periodontal/Gum Therapy or Surgery	❒ Yes ❒ No
Wisdom Teeth removed	❒ Yes ❒ No
Other dental procedures	❒ Yes ❒ No

Do you have any of the following conditions?

Bleeding gums	❒ Yes ❒ No
Receding gums/root exposure	❒ Yes ❒ No
Tooth pain/discomfort	❒ Yes ❒ No
Jaw Pain/TMJ pain	❒ Yes ❒ No
Clenching, grinding (Bruxism)	❒ Yes ❒ No
Mouthbreathing/snoring/sleep apnea	❒ Yes ❒ No
Tongue thrust	❒ Yes ❒ No

Have you had any injuries to your teeth, jaws or face? ❒ Yes ❒ No General Dentist:
Last Dental Check-up/Exam: Are any dental procedures currently planned or in progress? ❒ Yes ❒ No

PLEASE DESCRIBE ANY "YES" ANSWERS:

Please add other comments that you feel may be helpful:

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my health status.

Print Name: *Signature and Date:*

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Dr. Signature:

Please see reverse