ADULT HISTORY FORM - Welcome to Jupiter Orthodontics

We strive to provide you with the latest and most accurate information available so that you can make the best and most educated decisions for your treatment. Our goal is to offer you a relaxed, pleasant atmosphere while we create a beautiful smile that will last a lifetime.

Name: _____ Nickname: _____ ⬡ Male ⬡ Female Birth date:____/ ____/ _____
Street Address: _____ City: _____ State: _____ Zip: _____
Previous Address (If less than three years.) _____ How long? _____
Home Phone: ( ) _____ Bus. Phone: ( ) _____ Cell Phone: ( ) _____
Patient's Employer: _____ Position: _____ Start Date: _____
Patient's Social Security #: _____ - _____ - _____ Number of years in community: _____
E-mail Address: _____@_____ (This information is used for notification of appointments & for on-line access to your account. It is personal and is never disclosed to a third party.)
Spouse's Name: _____ Social Security #: _____ - _____ - _____ Birth date:____/ ____/ _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ Bus. Phone: ( ) _____ Cell Phone: ( ) _____
Spouce's Employer: _____ Position: _____ Start Date: _____
Emergency Contact: _____ Address: _____ Phone: ( ) _____

MEDICAL HISTORY

Have you had / experienced any of the following:

Y N Rheumatic fever
Y N Heart Disease
Y N Mitral Valve Prolapse
Y N Diabetes
Y N Asthma
Y N Cancer
Y N Allergies
Y N Convulsions
Y N Glaucoma
Y N Emotional problems / psychological guidance
Y N Bleeding disorders
Y N Hepatitis or AIDS
Y N Latex/rubber sensitivity
Y N Headaches
Y N Extensive X-ray therapy.
Y N Operations/injuries of the head or neck

Are you presently under the care of a physician? Y N If yes, what for? _____
Are you taking any medications? Y N Please list _____
Have you been ill for more that 5 consecutive days in the last year? Y N Name illness: _____
Have you had any overnight hospitalizations? Y N _____

DENTAL HISTORY

Have you had / experienced any of the following:

Y N Clicking / popping of the jaw joint
Y N Clenching/ grinding teeth at night
Y N Removal of any teeth
Y N Removal of tonsils / adenoids
Y N Mouth breathing (primarily)
Y N Speech problems

Are you aware of or concerned about your orthodontic problem? Y N _____
Dentist Name: _____ Date of last dental visit: _____
Do your require pre-medication before dental visits? Y N
Whom may we thank for referring you to our office? _____

AUTHORIZATIONS

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

In order to establish a payment plan for you, it will be necessary for us to run a credit report. ⬡ Yes ⬡ No

Signature _____ Date _____