VARGHESE ORTHODONTICS

It's all about your smile

ADULT FORM

Date _____

Patient's Name: _____ Birthdate: _____

Home Address: _____ City: _____ State:_____ Zip_____

Home #: _____ Cell #: _____ Work #_____

Employer:_____ Occupation:_____ # years employed_____

When/where are the best times to reach you? _____ Email Address: _____

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

Other family members seen by Dr. Varghese _____

General Dentist: _____ Date of last visit: _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

SPOUSE INFORMATION

Name: _____ Cell #: _____ Email:_____

Employer:_____ Occupation:_____ # years employed_____

INSURANCE INFORMATION

Primary Insurance: Dental Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____Phone #: _____Insured's Birthdate: _____

Insured's Social Security #:_____ Insurance Co. Address: _____

Insured's Name:_____Relationship:_____ Group (Plan/Local/Policy)#: _____

Insured's Employer: _____ Employer's Address: _____

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relationship: _____Phone#_____

MEDICAL HISTORY

Do you have a personal physician?

☐ Yes ☐ No

For Women: Is there a chance you could be pregnant?

☐ Yes ☐ No

Physician's Name: _____ Phone #: _____ Last Visit: _____

Do you smoke or use tobacco of any form?

☐ Yes ☐ No

Are you currently under the care of a physician?

☐ Yes ☐ No If yes, please explain _____

Are you taking any prescription/over-the-counter/herbal drugs? ☐ Yes ☐ No If Yes, Please List: _____

Have you ever had/experienced any of the following?

- ☐ Abnormal Bleeding
- ☐ AIDS/HIV+
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial bones joints/valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy/Convulsions
- ☐ Fever Blisters/Herpes
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Surgery/ Pacemaker
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Severe Headaches
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers/Colitis
- ☐ Venereal Disease

Please list any serious medical condition(s) you have had or you feel we should be aware of: _____

Have you had any major operations/surgeries: Yes No If yes, please explain: _____

Please list any drugs/materials that you are allergic to: _____Allergy to latex?_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to address? _____

Have you ever been evaluated for orthodontic treatment? Yes No By whom? _____ When? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental work? Yes No

# of time you brush daily? _____

Do you floss your teeth daily? Yes No

Do you have any of the following habits?
Lip Sucking/Biting Nail Biting Tongue Thrust Clench/Grind Teeth Other _____

Do you generally breathe through your mouth? Yes No If yes: While Awake While Asleep

Do you have any missing/extra permanent teeth? _____ Do you have any speech problems? _____

Do your gums bleed? Yes No

Do you still have any wisdom teeth? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

ADDITIONAL INFORMATION

Any additional information you can give us would be appreciated as the more we know about each other, the better we can help manage your treatment both at home and in the office.

_____

I affirm that the information I have given is correct to the best of my knowledge and that is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need. I also understand that my diagnostic records may be used for educational and promotional purposes. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. If this office accepts 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.

Signature: _____ Date: _____