SpeaksOrthodontics
Smile Big...Smile Often!

Date_____

Adult Patient Information

First Name _____ Last Name_____ Middle Initial _____
SSN _____ Birthdate _____ Age_____ Gender _____
Address _____ City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____
Occupation_____ Employer_____
Whom may we thank for recommending us? _____
What is your primary concern for Dr. Speaks to address?
_____

Orthodontic Insurance Information

Policy holder name _____ Birthdate _____
Insurance Company _____ SSN/ID _____ Group # _____

Dental History

Dentist _____ Practice _____Date of last visit _____
Have you been examined / treated by an orthodontist previously? _____
How would you describe your attitude towards orthodontic treatment? _____

Please check any of the following if applicable:

- ☐ Injuries to face, mouth or teeth
- ☐ Irritation to lip, cheek or gums
- ☐ Thumb, finger, or lip sucking
- ☐ Tongue thrusting or lisp
- ☐ Speech difficulties
- ☐ Chipped or injured permanent teeth
- ☐ Missing or extra permanent teeth
- ☐ Teeth removed by extraction
- ☐ Clenching or grinding
- ☐ Jaw joint sounds, pain or soreness
- ☐ Ringing in ears or difficulty chewing
- ☐ Diagnosed w/ gum disease or pyorrhea
- ☐ Treated for “TMJ” or “TMD”
- ☐ Previous difficulty w/ dental treatment

Treatment Motivation

Please indicate any of the following that may apply to help us understand your wishes regarding orthodontic treatment:

- ☐ Straighten teeth
- ☐ Move upper teeth
- ☐ Move lower teeth
- ☐ Move midline of the upper teeth
- ☐ Move midline of the lower teeth
- ☐ Upper teeth and gums show too much
- ☐ Lower teeth and gums show too much
- ☐ Move upper lip
- ☐ Move lower lip
- ☐ Move upper jaw
- ☐ Move lower jaw
- ☐ Move chin to center

Other changes desired: _____

OVER >>

Sleep / Airways Issues

Do you tend to be a mouth-breather? ☐ yes ☐ no

Has anyone observed you stop breathing? ☐ yes ☐ no

Do you wake up still tired in the morning? ☐ yes ☐ no

Do you often snore at night? ☐ yes ☐ no

Are you often tired during the day? ☐ yes ☐ no

Medical History

Physician _____ Phone _____

Medication currently being taken _____

Allergies to latex ☐ yes ☐ no

Medication allergies _____

Other allergies _____

Hospitalizations _____

Pregnant or anticipating pregnancy? ☐ yes ☐ no

Please check any of the following if applicable:

- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Arthritic/ Rheumatoid conditions
- ☐ Artificial joints / valves / implants
- ☐ Asthma / respiratory problems
- ☐ ADHD / sensory problems
- ☐ Birth defects / hereditary issues
- ☐ Cardiovascular problems
- ☐ Cancer / tumor
- ☐ Chest pain, shortness of breath
- ☐ Diabetes
- ☐ Dizziness / fainting
- ☐ Ear / nose / throat / eye disease
- ☐ Eating disorder
- ☐ Endocrine / thyroid problems
- ☐ Epilepsy
- ☐ Frequent headaches or migraines
- ☐ Gastrointestinal disorder
- ☐ Heart murmur
- ☐ Hepatitis / liver problems
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Immune system problems
- ☐ Kidney problems
- ☐ Mental / emotional problems
- ☐ Nervous system disorders
- ☐ Osteoporosis
- ☐ Radiation / chemotherapy
- ☐ Rheumatoid disorders
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Vision / hearing problems

Other _____

Release and Waiver

I have read and understand the above questions. I will not hold the orthodontist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform this practice of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need.

Signature _____ **Date** _____

I have read a copy of this office's Notice of Privacy Practices. If you would like a copy for your records please request.

Signature _____ **Date** _____