Mischler Orthodontics

NEW PATIENT FORM - ADULT

This form is to be used for patients ages 18 and older.

PATIENT INFORMATION

Patient Name _____

Nickname or Preferred Name _____

Date of Birth _____ Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

_____

Other Family Members Treated at Our Office

_____

Who Referred You to Our Office?

_____ _____

Name of Dentist | Approximate Date of Last Visit

RESPONSIBLE PARTY INFORMATION

_____ _____

Dental Insurance Company | Subscriber Date of Birth

PATIENT INFORMATION

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Physician Name _____
First Last

Date of Last Visit _____ Current Physical health is: Good Fair Poor

Have Tonsils or Adenoids been removed? Yes No

Are you taking prescription/over-the-counter medications? Yes No

Have you ever had any of the following medical problems or diseases?

Abdominal bleeding/Hemophilia
Anemia
Artificial Bones/Joints/Valves
Asthma
Blood Transfusion
Cancer/Chemotherapy
Congenital Heart Defect
Difficulty Breathing
Colitis
Diabetes
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack/Surgery
Heart Murmur
Hepatitis
Herpes/Fever Blisters
High Blood Pressure
HIV/AIDS
Kidney Problems
Latex Allergy
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Nickel Allergy
Psychiatric Problems
Rheumatic/Scarlet Fever
Shingles
Sinus Problems
Thyroid Problems
Prosthetics
Radiation Treatment
Seizures
Sickle Cell Disease
Stroke
Tuberculosis
Any Hospitalization

Do you have any of the following habits?

Clenching/Grinding Teeth
Lip Sucking/Biting
Mouth Breathing
Nail Biting
Speech Problems
Thumb/Finger Sucking
Tongue Thrust
Pacifier Usage

Please list any known allergies: _____

_____

_____

Have you ever been evaluated for orthodontic treatment? Yes No

Have you ever experienced pain or discomfort in the jaw joint (TMJ/TMD)? Yes No

Have you ever had an injury to your: (Select all that apply) Mouth Teeth Chin

ATTESTATION

I understand that the information provided in this form is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. I understand that I am responsible for payment of services rendered and for any co-payment that my insurance does not cover, including the deductible. I understand that I am responsible for all costs of orthodontic treatment. I herby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Signature of Parent or Guardian * _____