We look forward to seeing you:
_____ at _____am / pm
We would appreciate you arriving 10 minutes before the appt time with this form completed.

Summers orthodontics

Jeffery C. Summers, DMD

Today's Date: _____

ADULT FORM

Please take this time to tell us about yourself.

Name:_____
First Middle Last

Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑

I prefer to be called _____ ❑Male ❑Female
Nickname

Birth Date_____/_____/_____ Age:_____

Social Security #:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____) _____

Cell Phone: (_____) _____

E-mail Address: _____

Hobbies: _____

Single❑ Married❑ Divorced❑ Separated❑ Widowed❑

Children (Please list names and ages.)

_____

_____

_____

Have any other family been seen in our office? Names:

_____

How did you hear about our office? _____

Who may we thank for referring you to our office?

INSURANCE

Primary Dental Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone:(_____) _____

Insured Name: _____

Relation to Patient:_____ Birth Date: _____/_____/_____

SS#:_____ Group #:_____

Secondary Dental Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone:(_____) _____

Insured Name: _____

Relation to Patient:_____ Birth Date: _____/_____/_____

SS#:_____ Group #:_____

EMPLOYER INFORMATION

Employer:_____

Occupation: _____

Work Address: _____

City:_____ State:_____ Zip:_____

Work:(_____)_____ How long there?_____

SPOUSE INFORMATION

His / Her Name:_____

Birth Date:_____/_____/_____ Age:_____

Social Security #:_____

Employer:_____

Occupation:_____

Work Phone:(_____) _____ Ext. _____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relationship_____

Billing Address: _____

City:_____ State:_____ Zip:_____

Home:(_____) _____ Cell:(_____) _____

Emergency Contact: _____

Relation:_____ **Phone:(**_____**)** _____

GENERAL DENTIST

Name:_____

Last Dental Exam: _____

My dentist referred me to:

❑ You ❑ Another Orthodontist ❑ None

Continued on other side . . .

Member American Association of Orthodontists

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Taylors, SC 29687

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fax (864) 244-7767
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MEDICAL HISTORY

A complete history is vital for a proper orthodontic evaluation.

Physician: _____

Phone No:_____ Date of last visit: _____

Are you taking any prescription medication: ❑ Yes ❑ No

If yes, please list which one(s): _____

_____

For Women: Are you pregnant? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems? (Please circle all that apply.)

Abnormal Bleeding	**Hepatitis**
AIDS or HIV positive	**Immune System**
Artificial Bones / Joints	**Jaundice or Liver Problems**
Asthma	**Kidney Problems**
Birth Defects	**Mental Health / Behavioral**
Blood Pressure-High or Low	**Mitral Valve Prolapse**
Bone Disorders	**Nervous Problems**
Cancer or Tumors	**Neurological Problems**
Chest Pain	**Pneumonia**
Congenital Heart Defect	**Polio, Mono or Tuberculosis**
Convulsions	**Prosthetics**
Diabetes	**Radiation / Chemotherapy**
Ear, Nose or Throat	**Rheumatic or Scarlet Fever**
Endocrine or Thyroid	**Rheumatoid / Arthritic**
Epilepsy	**Sickle Cell Disease / Traits**
Excessive Weight Loss/Gain	**Skin Disorders**
Fainting Spells or Seizures	**Speech Difficulties**
Handicap / Disabilities	**Stomach Ulcers/Hyperacidity**
Hay Fever or Sinus Trouble	**Swelling Ankles**
Hearing Impairment	**Tuberculosis**
Heart Trouble / Murmur	**Vision Difficulties**

Any Hospital Stays / Operations? _____

_____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

MEDICAL ALERT INFORMATION

Do you normally require antibiotic pre-medication prior to dental procedures? ❑ Yes ❑ No _____

Are you allergic to any of the following?

Latex	❑ Yes ❑ No	Plastic	❑ Yes ❑ No
Nickel	❑ Yes ❑ No	Aspirin	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Codeine	❑ Yes ❑ No

List any other allergies:_____

Are you currently taking or have you ever taken intravenous bishophonates for serious bone disorder/cancers: such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)? ❑ Yes ❑ No

Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidonate)? ❑ Yes ❑ No

Being treated by another health care professional? ❑ Yes ❑ No

For: _____

Date of most recent physical exam? _____

DENTAL HISTORY

Have you ever been evaluated by an Orthodontist? ❑ Yes ❑ No

If so, by whom?_____

Have you ever had orthodontic treatment? ❑ Yes ❑ No

If so, by whom? _____

Were you happy with the results? ❑ Yes ❑ No

Have other members of your family had orthodontic treatment?

❑ Yes ❑ No Were you happy with the results? ❑ Yes ❑ No

By whom (if other than Dr. Summers)?_____

Chief complaint or reason for your visit today? _____

_____

Appearance

If you could change one thing with the appearance of your teeth or your bite, what would it be? _____

_____

Are you happy with your smile? ❑ Yes ❑ No

Do you like the shape of your teeth? ❑ Yes ❑ No

Are you happy with your profile and jaw line? ❑ Yes ❑ No

Are you happy with the amount of gum tissue that you show when smiling? ❑ Yes ❑ No

Function

Do you experience pain, clicking or discomfort in or near your ears? ❑ Yes ❑ No

Do you have pain or tenderness in your jaw joints (TMJ / TMD)? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

Have you been informed of missing or extra permanent teeth? ❑ Yes ❑ No

Are you aware of any gum problems? ❑ Yes ❑ No

Have your tonsils or adenoids been removed? ❑ Yes ❑ No

Habits

Do you or did you have any of the follow habits? (Please circle)

Clenching / Grinding Teeth — Lip Sucking / Biting

Mouth Breather — Nail Biting

Thumb / Finger Sucker (Until: _____ age)

I hereby certify that I have reviewed the above medical and dental history and agree that it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

_____ _____

Patient's Signature **Date**

_____ _____

Doctor's Signature **Date**

smiles for a lifetime