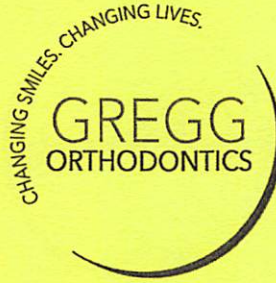


Adult forms



Confidential Patient Information

Name _____ Marital Status _____
Last First Middle

Residence _____ Own Rent
(No P.O. Box's please) Street City Zip

Yrs at this address _____ Previous Address (if less than 3yrs) _____
Street City, St Zip

Primary cell phone number _____ Work phone _____

Email address _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Name _____

Employer _____ Occupation _____ # Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

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

Dental Insurance Information

Insured 's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____

Do you have **dual** coverage? Yes _____ No _____ IF Yes:

Insured's Name _____ Insured's Social Security # _____

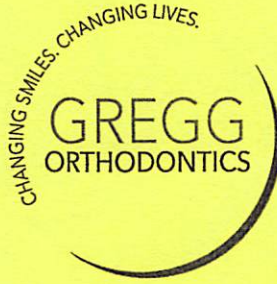
Insurance Company _____ Group No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Benjamin Gregg to perform a complete orthodontic evaluation. I understand where appropriate, credit bureau reports will be obtained.

Signature: (Parents signature if minor) _____ Date: _____



Medical History

Physician _____ Date of Last Visit _____

Please **circle** Yes or No (If **Yes**, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Are you currently under the care of physician? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Asthma or Hayfever	Fever blisters	High Blood Pressure
Anemia	Diabetes	Heart Murmur	HIV/Aids
Arthritis	Epilepsy	Hepatitis/Liver problems	Prolonged Bleeding
			Radiation/Chemotherapy

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

Dental History

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Have you ever been told that you clinch or grind your teeth? _____
Yes No Do you have "tension" headaches? _____

Female Patients only: Are you pregnant? Yes _____ No _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Phone _____ Street _____ City _____ Zip _____
Relationship _____