Small & Martin Orthodontics

PLEASE PRINT

Welcome to Our Office

DATE:___________

ADULT PATIENT INFORMATION

Patient's Name____ SS#________________

Address ___________________________________ City__________ State________ Zip__________

Sex ❑ M ❑ F Age_______ Birthdate____/____/____ Home Phone______________________

Cell Phone ________________________ Can we text appointment reminders to you? Y/N _________

Email Address ____

Name of Patient's Employment or School _________________________ Work Phone_____________

Spouse's Name ____ SS#________________

Cell Phone _______________________ Email Address ____________________________________

Spouse's Place of Employment ___________________________ Work Phone _________________

FINANCIAL

Person Responsible for Payments Name ___________________________ SS#________________

Address ___________________________________ City__________ State________ Zip__________

Home Phone _________________ Cell Phone________________ Work Phone _________________

Place of Employment ____

Email Address ____

Do you have insurance or any other program that might assist you in paying for treatment? __________

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MEDICAL HISTORY

Please check any of the following as they apply:

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Rheumatic fever
- ❑ Heart disease
- ❑ Bleeding problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ AIDS
- ❑ Allergies
- ❑ Pregnancy
- ❑ Hearing problems
- ❑ Speech problems
- ❑ Fainting or dizzy spells
- ❑ Learning disabilities
- ❑ Emotional problems
- ❑ High blood pressure
- ❑ Injuries to jaw or face
- ❑ Grinding of teeth
- ❑ Injury to mouth
- ❑ Thumb or finger sucking habits
- ❑ Lip or tongue biting habits
- ❑ Pain or clicking of jaw joint
- ❑ Early loss of baby teeth
- ❑ Bleeding gums

•Is the patient now under any medication? Y/N What?______________ Why? ____________________

•Is the patient now under care of a physician? Y?N If yes, Physician's Name ____________________

•Has the patient ever been hospitalized or suffered illness? Y/N If yes, What and When ____________

____/___/___

GENERAL INFORMATION

•Who is the patient's general dentist? ______________________ Date of last cleaning ___/___/___

•Who may we thank for recommending you to our office?___________________________________

•Have you had any previous family members in treatment in our office? Y/N If yes, please list below:

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