[redacted]

Patient Information Record
(Adult)

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Patient's Full Name	Preferred Name		Age
Address	City	State/Zip	Date of Birth
How long at this address? ☐ Rent ☐ Own	Employer		
SSN	Home Phone	Cell Phone	Work Phone
Occupation		How long?	D.O.B.
Spouse	SSN	Cell Phone	Work Phone
Occupation	Employed By	How long?	D.O.B.
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed	Responsible Party	Email	
Child(ren): ☐ Yes ☐ No	Name/Age	Name/Age	Name/Age	Name/Age
Responsible Party	Relationship to Patient	SSN	
Address	City	State/Zip	Home Phone
Employed By	How long?	Cell Phone	Work Phone
Driver's License Number	Insurance Company	ID#	
Insured's Name	Relationship to patient	D.O.B.	SSN
I authorize Dr. Oakes to file insurance benefits on my behalf. Signature:	I have received and read the HIPPA acknowledgement Initial:		
Dentist	Physician	Referral by	

Medical History - *Have you ever had (or have) any of the following: (please check)*

☐ Heart Problem ☐ Epilepsy ☐ Arthritis ☐ Emotional Problems
☐ Rheumatic Fever ☐ Hepatitis/Jaundice ☐ Radiation Therapy ☐ Prolonged Bleeding
☐ Bone Disorders ☐ HIV/Aids ☐ Allergies/Asthma ☐ Fainting or Dizziness
☐ Tuberculosis ☐ Diabetes ☐ Speech/Hearing Problems ☐ Frequent Headaches
☐ Kidney Involvement ☐ Major Operation ☐ Blood Transfusion
☐ Endocrine Problems ☐ Anemia ☐ Other

Dental History - *Have you ever had (or have) any of the following: (please check)*

☐ Injury to face/teeth, jaws, head ☐ Clenching/grinding teeth ☐ Extraction of teeth ☐ Pain in jaw joint or muscles
☐ Thumb/finger sucking ☐ Periodontal disease ☐ Extra or missing permanent teeth ☐ Jaw joint locked or out-of-joint
☐ Mouth Breathing ☐ Root canal treatment ☐ Clicking/popping in jaw ☐ Other dental problems

Is patient presently under the care of a physician? ☐ Yes ☐ No If so, for what? _____

List all medicines (including herbal supplements) patient is currently taking _____

List all drugs or medicines to which patient has had a reaction or is allergic _____

Have tonsils and/or adenoids been removed? ☐ Yes ☐ No What age? _____

Signature	Date