BODINE
ORTHODONTICS

ADULT PATIENT INFORMATION

TITLE ☐ Dr. ☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.

NAME _____ PREFERRED NAME _____

BIRTHDATE _____ AGE _____ GENDER ☐ MALE ☐ FEMALE

ADDRESS (home) _____# OF YEARS @ ADDRESSS _____

PHONE (home) _____ (work) _____ (cell) _____

EMAIL _____ SSN _____

EMPLOYER _____ # OF YEARS_____ OCCUPATION _____

DENTIST _____DATE OF LAST VISIT _____

HAS PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP_____

ADDRESS (home) _____

PHONE (home) _____ (work) _____ (cell) _____

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? _____

WHOM MAY WE THANK FOR REFERRING YOU TO BODINE ORTHODONTICS? _____

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that is it our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME _____ **SIGNATURE** _____ **DATE** _____

(OVER)

DENTAL HISTORY

CHECK IF YOU CURRENLTY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

☐ Blisters on lips/mouth	☐ Grinding teeth	☐ Jaw surgery	☐ Periodontal surgery
☐ Broken fillings	☐ Gums bleeding	☐ Lip/cheek biting	☐ Sensitivity to hot or cold
☐ Burning sensation, tongue	☐ Gums sore/swollen	☐ Loose teeth (other than baby teeth)	☐ Sensitivity to sweets
☐ Chews on tongue	☐ Injuries to teeth/jaw	☐ Mouth breathing	☐ Sensitivity to pressure
☐ Dry mouth	☐ Injuries to face/head	☐ Mouth pain when brushing	☐ Sores/growths in mouth
☐ Extracted teeth	☐ Jaw clicking/popping	☐ Orthodontic treatment	☐ Speech problems
☐ Finger/thumb habits	☐ Jaw locking open/closed	☐ Pain around ear	☐ Tongue thrust
☐ Food trapped between teeth	☐ Jaw pain/tenderness	☐ Periodontal treatment	

HOW OFTEN DO YOU BRUSH? _____ FLOSS? _____

ADDITIONAL COMMENTS _____

MEDICAL HISTORY

CHECK IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

☐ AIDS	☐ Chemotherapy	☐ Hepatitis	☐ Scarlet fever
☐ Anemia	☐ Circulatory problems	☐ High blood pressure	☐ Shortness of breath
☐ Arthritis	☐ Cortisone treatment	☐ HIV Positive	☐ Stroke
☐ Artificial heart valves	☐ Coughing - persistent	☐ Kidney disease	☐ Stomach ulcers
☐ Artificial joints	☐ Diabetes	☐ Liver disease	☐ Swelling of feet
☐ Asthma	☐ Epilepsy	☐ Mitral valve prolapse	☐ Thyroid problems
☐ Back problems	☐ Fainting	☐ Nervous system problems	☐ Tobacco habit
☐ Blood diseases	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Bone disorders	☐ Headaches	☐ Psychiatric Care	☐ Tonsils removed
☐ Cancer	☐ Heart murmur	☐ Radiation treatment	☐ Tuberculosis
☐ Chemical dependency	☐ Heart problems	☐ Respiratory disease	☐ Urinary problems
☐ Other (not listed) _____			

FEMALES ONLY IS IT POSSIBLE THAT YOU ARE PREGNANT? ☐ YES ☐ NO IF SO, HOW FAR ALONG? _____

ARE YOU UNDER THE CARE OF A PHYSICAIN? ☐ YES ☐ NO FOR WHAT CONDITION? _____

PHYSICAIN'S NAME _____ PHONE _____

MEDICATIONS

Please list **ANY & ALL** medications that you are currently taking:

_____

_____

ALLERGIES

Please list **ANY & ALL** known allergies you are aware of:

_____

_____

ARE YOU CURRENLY TAKING OR HAVE TAKEN IN THE PAST ANY BONE DENSITY MEDICATIONS? ☐ YES ☐ NO
(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Foasmax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. It is my responsibility to inform this office of any changes in my personal information or health status. I will not hold Bodine Orthodontics or the staff responsible for any errors or omissions that I have made in the completion of this form

NAME _____ **SIGNATURE** _____ **DATE** _____