OWENS ORTHODONTICS

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SPECIALISTS IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS
CERTIFIED BY THE AMERICAN BOARD OF ORTHODONTICS

Today's Date:_____ **ADULT**

Patient's Name:_____ D.O.B.:_____ Age:_____

Mailing Address:_____ City/State/Zip:_____

Primary Phone#:_____ Male:_____ Female:_____ Preferred Name:_____

Email Address:_____

Spouse's Name:_____ Phone #:_____

General Dentist:_____ Last Visit:_____Were teeth cleaned?:_____

Other Family Members Seen by Us:_____

Orthodontic consult prompted by: Dentist Self Physician Friend Other_____

Does the patient have Orthodontic Insurance? Y N <u>If Yes, please present ID card to receptionist and answer the following</u>:

Name of the Policy Holder: _____ Birth Date: _____

Relationship to Patient:_____ SS#:_____

<u>EMERGENCY CONTACT:</u> Name:_____ Relationship:_____

Phone#:_____

<u>MEDICAL HISTORY:</u>

Have you ever had:

Asthma	Bone Disorders	Endocrine Problems	Hearing Disorder	Hepatitis
Anemia	Diabetes	Emotional Disorders	Head or Face Injury	Herpes
Epilepsy	Blood Disease	Rheumatic Fever	Heart Disease	Birth Defects

Other (Please Describe):_____

Have you been under the care of a physician during the past two years other than routine examinations?

Condition:_____Current Medications:_____

_____

DENTAL HISTORY:

Pain or Clicking in Jaw Joints? Yes No

Have any teeth been injured due to accidents? Yes No

Have you had any unusual dental experiences/conditions? Yes No

Please Specify:_____

ORTHODONTIC HISTORY:

Have you had orthodontic treatment in the past? Yes No When?_____

Orthodontist's Name:_____ City/State:_____

Main Concerns you have about your Teeth/Smile:_____

You will receive either a text OR email appointment reminder the day before each appointment.
Please choose which you would prefer:

Text: Phone # _____

Email: Address _____

Name of person completing this form: _____

Signature:_____ Date:_____