ADULT
PATIENT INFORMATION
& MEDICAL HISTORY

Great Smiles
ORTHODONTIC SPECIALISTS
BeGreatDental.com

Ryan J. Haldeman, DDS, MS, PA
Stephanie S. Chambers, DDS, MS, MSD
Anthony Paul Blackman, DMD, MSD

Patient Information

Date _____

Patient's Name _____ (First / Middle / Last) Preferred Name _____ Sex _____

Street Address _____ Date of Birth _____

Physician Name _____ Dentist _____

Preferred Number _____ Whom may we thank for referring you? _____

Responsible Party Information

Name _____ (First / Middle / Last) Marital Status: ❑ Single ❑ Separated ❑ Married ❑ Divorced

Email Address _____ Preferred Phone # _____ Work # _____

Mailing Address _____ (Street/P.O. Box / City / State / Zip) ❑ Own ❑ Rent How long at this address _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ (If self-employed, list name of business) Occupation _____ No. Years Employed _____

Spouse/(Other) _____ (First / Middle / Last) Relationship to Patient _____

Spouse's/(Other's) Email: _____ Preferred Phone # _____ Work # _____

Mailing Address _____ (Street/P.O. Box / City / State / Zip) ❑ Own ❑ Rent How long at this address _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ (If self-employed, list name of business) Occupation _____ No. Years Employed _____

Dental Insurance Information

Policy Holder's Name _____ Insured's Soc Sec. # _____ Birthdate ____/____/____

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____ Do you have other dental insurance? ❑ No ❑ Yes

Emergency Information

Name of nearest emergency contact not living with you _____ Phone No. _____

Address _____ (Street / City / State / Zip) Relationship to Patient _____

I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature _____ Date _____

ADULT HEALTH HISTORY

MEDICAL HISTORY

Have you ever had any of the following medical problems?

Y	N	**Latex Allergy**	Y	N	Heart Murmur	Y	N	Hyperactive
Y	N	Allergies	Y	N	Convulsion/Epilepsy	Y	N	Lung Problems
Y	N	Anemia	Y	N	Diabetes	Y	N	Mental Disorder
Y	N	Asthma	Y	N	Drug/Alcohol Abuse	Y	N	Nervous System Disorder
Y	N	Bleeding Disorder/Hemophilia	Y	N	Fainting	Y	N	Pregnant
Y	N	Bronchitis	Y	N	Handicap/Disabilities	Y	N	Rheumatic Fever
Y	N	Cancer/Chemotherapy	Y	N	Hearing Impairment	Y	N	Speech Disorder
Y	N	Cerebral Palsy	Y	N	Hepatitis	Y	N	Tuberculosis
Y	N	Congenital Heart Defect	Y	N	HIV/AIDS	Y	N	Tumors/Growths

Office Use Only: Doctor's Comments _____

_____

Have you experienced any other physical or mental disorder that is not listed above? Yes ❑ No ❑

If yes, please describe: _____

Has any immediate family member had any of the above? Yes ❑ No ❑ If Yes, please describe: _____

_____

Are you allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Are you allergic to any other drugs? Yes ❑ No ❑ If Yes, please list: _____

Are you presently under the care of a physician for any illness? Yes ❑ No ❑ If Yes, please list: _____

_____

List any drugs or medicines presently being taken: _____

Have you ever been hospitalized? Yes ❑ No ❑ If Yes, please give reason and date(s) _____

DENTAL HISTORY

Reason for orthodontic consultation _____

Yes	No	
____	____	Has an orthodontist been consulted previously? Name:
____	____	Have you been informed of any missing or extra permanent teeth?
____	____	Have there been injuries to the face, mouth, or teeth?
____	____	Do you have pain with chewing, yawning, or wide opening?
____	____	Does your jaw make noise and is pain associated with the sounds?
____	____	Have you ever had orthodontic treatment?

Date of last dental examination _____

May we request release of your medical records? Yes ❑ No ❑

Thank you for your help. If there is any information that you feel might be of value to us during your treatment, please add it here:

_____

_____

_____