

**ADULT  
PATIENT INFORMATION  
& MEDICAL HISTORY**



10A Yorkshire Street, Suite C • Asheville, NC 28803  
828-274-8822 • fax 828-274-8833

50 Bowman Drive • Waynesville, NC 28785  
828-407-4034 • fax 828-454-9158

37 Crestview Heights • Sylva, NC 28779  
828-586-9333 • fax 828-586-9248

Ryan J. Haldeman, DDS, MS, PA • Stephanie S. Chambers, DDS, MS, MSD

GreatSmilesOrthodontics.com

**Patient Information**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
First Middle Last Preferred Name \_\_\_\_\_ Sex \_\_\_\_\_  
Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient's Physician Name \_\_\_\_\_ Patient's Dentist \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_ Marital Status:  Single  Separated  
First Middle Last  Married  Divorced  
Email Address \_\_\_\_\_ Preferred Phone # \_\_\_\_\_  
Mailing Address \_\_\_\_\_  Own  Rent  
Street/P.O. Box City State Zip  
How long at this address \_\_\_\_\_ Home Phone Number \_\_\_\_\_ Work Phone \_\_\_\_\_  
Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip  
Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
(if self-employed, list name of business)  
Spouse/(Other) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
First Middle Last  
Spouse's/(Other's) Address (if different) \_\_\_\_\_  
Street City State Zip  
Spouse's)/(Other's) Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
(if self-employed, list name of business)  
Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**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 \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Street City State Zip

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL HISTORY

Have you ever had any of the following medical problems?

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

Blank lines for additional information.