PATIENT INFORMATION SHEET - ADULT

Patient Name: _____ Gender: _____

Preferred Name: _____ Patients' Birthdate: _____/_____/_____ Age: _____
month / day / year

Address: _____ (please include postal code)

Home Phone #: (_____) _____ - _____ Cell Phone #: (_____) _____ - _____ Carrier (ex. Fido, Rogers): _____

E-mail address: _____

We send an email/text message reminding you of your appointment. Please indicate the main cell phone (and carrier) and email address for your reminders.

Cell phone: _____ **Carrier (ex. Fido, Rogers):** _____

Email: _____

Is there anyone else who will be financially responsible for your treatment? YES / NO

If yes, please provide their information below:

Name: _____ *Relationship to patient:* _____

Address same as patient's above? Yes ____ No ____ If No: _____

Cell Phone #: (_____) _____ - _____ Carrier (ex. Fido, Rogers): _____ Home Phone #: (_____) _____-_____

Work Phone #: (____) _____-_____ E-mail address_____

We would like to call your insurance company prior to your appointment to provide you with the most accurate and up-to-date information possible.

Do you have Dental Insurance YES / NO

Primary Insurance

Name of Subscriber _____Date of Birth_____

Insurance Company_____ Group#_____ Certificate # (Id#)_____

Secondary Insurance

Name of Subscriber _____Date of Birth_____

Insurance Company_____ Group#_____ Certificate # (Id#)_____

Medical History

Do you:

Have allergies? Yes____ No ____ If yes, what type? _____

Have any conditions that affect the immune system (AIDS, HIV, Leukemia)? Y N

Bruise easily after injury? Y N

Experience prolonged bleeding after injury? Y N

Have you ever had:

Surgery with general anesthetic		Y	N	If yes, what type? _____			
Rheumatic fever	Y	N	Diabetes		Y	N	
Chronic kidney problems	Y	N	Heart problems		Y	N	
Lung problems		Y	N	Liver problems		Y	N
Epilepsy	Y	N	Cerebral palsy		Y	N	
Abnormal bleeding problems		Y	N	Prosthetic joint		Y	N
Bronchitis		Y	N	Head/ear aches		Y	N

Please list any medications used regularly: _____

Any other medical information/dental-related concerns you would like us to know about? _____

_____

Dental History

What are the main concerns regarding your teeth? _____

_____

Who is your family dentist? _____

How did you hear about our office? (Please circle all that apply) Friend or Family (Name: _____)

Google Social Media (Facebook, Instagram, etc) Internet Search Dentist Referral

Advertisement Doctor Locator on Invisalign website Doctor locator on Damon website Other

Do you:

Want orthodontic treatment?		Y	N	
See your general dentist regularly?	Y	N	Last visit: _____	
Smoke or chew tobacco?	Y	N		
Grind your teeth at night?	Y	N	If yes, do you wear a mouthguard?	Y N

Have you:

Ever had previous orthodontic consultations/treatment?	Y	N	
Ever had problems with sore gums?	Y	N	
Ever seen a periodontist regarding gum health?	Y	N	Last visit: _____
Ever received a severe blow to the teeth or jaws?	Y	N	

I, _____, give permission to allow Dr. Dueckman and Dr. Felty (and/or staff) to report any findings to my dentist or any other dental professional as they deem necessary.

Signature: _____ Date: _____