## 3 MEDICAL AND DENTAL HISTORY

Please circle Y or N for each question

Y N Have you had tonsils and adenoids removed? When?

Y N Do you have any endocrine (hormone) disturbances? (eg. diabetes, thyroid, etc.)

Y N Do you bleed for a prolonged period when cut or after tooth extractions?

Y N Do you have any heart, lung, kidney or digestive tract problems? Which?

Y N Are you taking any medications now? Please list.

Y N Are you allergic to any medications? Please list.

Y N Are you allergic to any metals or latex? Which?

Y N Do you suffer from asthma or bronchitis?

Y N Have you ever had seizures? Medications?

Y N Have you ever been under the care of a physician for illness? Please list.

Y N Have you ever had rheumatic fever?

Y N Have you ever had a positive test for HIV, AIDS, or Hepatitis?

Y N Have any teeth ever been extracted?

Y N Are you aware of any missing or extra teeth?

Y N Have you ever suffered any injury to the face? What and when?

Y N Have any teeth been injured due to an accident or fall?

Y N Are you apprehensive toward dental visits?

Y N Do you play a musical instrument with the mouth? Which instrument?

Y N Are you willing to wear braces if needed?

Y N Does your jaw ever pop or make noise? (if so, please ask to fill out an additional information sheet)

Y N Has your physician ever prescribed medication to strengthen your bones or to prevent or treat osteoporosis?

Y N Have you ever taken Actonel,Aredia,Boniva,Didronel, Fosamax, Skelid, Zometa, or any other Bisphosphonate drug?

What do you feel are the main problems with your teeth and/or bite?

How do you feel orthodontics can help?

## 4

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.
I also give permission to use my photo for the office website, facebook page, bulletin boards, etc.
I ALSO give permission for Innovative Orthodontics to give automated appointment reminder phone calls.

**X** Signature Date

**A B C**

www.innovativeorthodontics.com

2103 Broadway · Cape Girardeau, MO · 63701 · 573.33BRACE fax · 573.334.7379 · 404 S. Hope · Jackson · 63755 · 573.243.5985 · 12 South Jackson · Perryville · 63775 · 573.547.7411

ADULT FORM

Please use Black or Blue ink when filling out this form.

## OUR MISSION STATEMENT

It is our mission to deliver the highest quality orthodontic care and superior customer service to each of our patients in a relaxed and fun environment. We strive to continually improve our skills by staying current on advances in our field to ensure a first class experience with an excellent result.

## 1 ABOUT YOU

Patient's name Sex Birthdate Age

Address City State Zip

How long at this address Email

Home Phone Cell Phone Patient's dentist

Marital status: Married Divorced Single SS#

Special interests, sports or hobbies?

Children's names and ages

Have we seen any family member before? Y N If so, patient's name

Employer Address Phone

Occupation Years Employed

Orthodontic insurance? Y N Insurance company name

Insurance company address

I.D.# Group #

Limits of orthodontic coverage $

How did you hear about our office?

## SPOUSE INFORMATION

Spouse's name SS# Birthdate

Address City State Zip

Employer Occupation Years Employed

Business address Business phone Cell phone

Orthodontic insurance? Y N Insurance company name

Insurance company address

I.D.# Group #

Limits of orthodontic coverage $

## 2 ACCOUNT RESPONSIBILITY

Person responsible for account Address

I acknowledge that where appropriate a Credit Bureau report may be obtained.

X Signature Date

**Thank you for taking the time to fill out this form completely.** It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. (573) 332-7223