

ADULT WELCOME FORM

Date _____

Patient name _____ Preferred Name _____

Gender _____ Age _____ Birth date _____ Email _____

Address (city, state, zip) _____

Best number to be contacted at _____ Cell Home Other _____

Occupation _____ Employer _____

EMERGENCY Contact/Relation _____ Phone Number _____

Whom may we thank for recommending our office to you? (Please check all that apply)

Google Facebook/Instagram Dentist Family/Friends Other _____

Past or Present Family Members in Treatment _____

Have you consulted an orthodontist previously? _____

Financial Information

self (if self, skip to next section)

Financially Responsible Party _____ Relationship to patient _____

Address (city, state, zip) _____

Best number to be contacted at _____ Birth date _____

Occupation _____ Employer _____

Medical/Dental History

Dentist _____ Date of last Dental cleaning _____

Past or current history of Smoking or Tobacco use? Yes No

Now or in the past, has the patient had:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Permanent teeth removed or congenitally missing teeth
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Severe head or face injuries
<input type="checkbox"/>	<input type="checkbox"/>	Bone/Joint Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Frequent oral habits (sucking finger, tongue thrust, chewing pen, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Tooth grinding or clenching
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Clicking, locking, or soreness in jaw joints (TMJ)

Please explain any medical/dental items checked 'yes' _____

See other side

Please list any other relevant medical conditions and/or allergies:

Patient taking any medications? Y N If yes, please list:

Please rate the following aspects of your orthodontic treatment in terms of their importance to you:

- 1) The comfort of the appliances used
 Not Important Slightly Important Moderately Important Important Very Important

- 2) Esthetic or clear appliances (clear braces vs metal braces vs clear aligners)
 Not Important Slightly Important Moderately Important Important Very Important

- 3) Low monthly payments
 Not Important Slightly Important Moderately Important Important Very Important

- 4) Ability to begin treatment within the next 30 days
 Not Important Slightly Important Moderately Important Important Very Important

I, the undersigned, have given the above information and certify that it is accurate. I have also received a copy of the Notice of Privacy Practices for Orthodontic Associates.

Signature _____ Date _____

I authorize the release of medical, dental, and/or financial information to the following:

- 1. _____ Relationship to Patient: _____
- 2. _____ Relationship to Patient: _____
- 3. _____ Relationship to Patient: _____