Vanderwall ORTHODONTICS

Clay VanderWall DDS PA

Adult's Personal Information Form

1. Tell us about you:

Today's date: _____ DOB:_____

Name: Age: _____

_____

Last First MI (Mr. Mrs. Ms.)

I prefer to be called: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Dr. Lic. #: _____ State _____

SS #: _____ Email: _____

Home Address: _____

_____ Apt. #: _____

City: _____ State: _____ Zip: _____

Dental Information:

Previous/Present Dentist: _____

Address: _____

Phone #: _____Last visit: _____

2. About your employer:

Name: _____

Address: _____

_____

How long have you worked there? _____

Occupation: _____

When and where are the best times to reach you?

_____

Who may we thank for referring you to us?

_____

List other family members seen by us: _____

_____

3. Spouse's Information:

Name: _____

Employer: _____

Work Phone #: _____

Dr. Lic. #: _____ State _____

SS #: _____

Date of birth: _____

4. Responsible Party Information:

Name: _____

Billing Address: _____

_____ Apt. #: _____

City: _____ State: _____ Zip: _____

Wk. Ph. #: _____ Hm. Ph. #: _____

Cell Phone #: _____

Employer: _____

Dr. Lic. #: _____ State _____

SS #: _____ Email: _____

Emergency Contact:

Name: _____ Relation: _____

Wk. Ph. #: _____ Hm. Ph. #: _____

5. Primary Dental Insurance:

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone Number: _____

Group/Policy Number: _____

Insured's Name: _____

Relationship to patient: _____

Insured's date of birth: _____

Insured's employer: _____

SS # of Insured: _____

Orthodontic coverage? ☐ Yes ☐ No

Secondary Dental Insurance:

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Ins. Co. Phone Number: _____

Group/Policy Number: _____

Insured's Name: _____

Relationship to patient: _____

Insured's date of birth: _____

Insured's employer: _____

SS # of Insured: _____

Orthodontic coverage? ☐ Yes ☐ No

6. Dental History:

Why have you come to the orthodontist today?

_____

Are you currently in pain? ☐ Yes ☐ No
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Have you ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Do you like your smile? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No
How many times per day do you brush? _____
How many times per day do you floss? _____
Types of bristles? ☐ Hard ☐ Medium ☐ Soft

7. Medical History:

Do you have a personal physician? ☐ Yes ☐ No
Physician: _____
Phone #: _____Last visit: _____
Your current health is:
☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a doctor?
☐ Yes ☐ No Explain: _____
Are you taking any prescription drugs? ☐ Yes ☐ No
If yes, please list: _____
_____

For Women Only:

Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

8. Have you had any of these diseases or medical problems?: (Please circle Yes or No)

Y N Prosthesis	Y N History of Scarlet Fever
Y N Heart Attack	Y N Congenital Heart Defect
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Artificial Valves
Y N HIV+/AIDS	Y N Heart Surgery/Pacemaker
Y N Hemophilia	Y N Hospital Stays
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Mitral Valve Prolapse
Y N Tuberculosis	Y N Artificial Bones/Joints
Y N Shingles	Y N Severe/Frequent Headaches
Y N Fever Blister	Y N High/Low Blood Pressure
Y N Venereal Disease	Y N Drug/Alcohol Abuse
Y N Ulcers/Colitis	Y N Blood Transfusion
Y N Heart Murmur	Y N Anemia/Radiation Treatment
Y N Emphysema	Y N Glaucoma
Y N Sinus Problems	Y N Difficulty Breathing
Y N Other: _____	

Have you ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease. (e.g. Fosamax, Zometa, Actonel, Aredia) Y N

Are you allergic to any of the following:

(Please circle Yes or No)

Y N Aspirin	Y N Erythromycin
Y N Codeine	Y N Dental Anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

9. I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

_____ _____
Signature of Patient Date

Payment is due at the time of service unless prior arrangements have been approved.

Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials: _____ Date: _____

Doctor's comments: _____
_____
_____
_____
_____
_____

1. Date: _____ Signature: _____
Comments: _____

2. Date: _____ Signature: _____
Comments: _____

3. Date: _____ Signature: _____
Comments: _____

4. Date: _____ Signature: _____
Comments: _____