PURAVIDA
ORTHODONTICS

Adult Patient Information

Name:_____Today's Date:_____
First Middle I. Last
Date of Birth:_____Age:_____ Sex: M / F Marital Status: S M D

Address:_____
Street City State Zip
Home Phone:_____Cell:_____Work:_____
Email: _____
Place of Employment_____Occupation_____

Dentist Name:_____ Location/Clinic_____
Physician's Name_____ Location/Clinic_____
Emergency Contact:_____ Phone:_____
How did you hear about our clinic?_____

Responsible Party Information

___ Name:_____ E-mail:_____
Address:_____ Date of Birth:_____
Home Phone:_____ Cell:_____ Work:_____
Employer:_____ Occupation:_____

___ Spouse's Name:_____ E-mail:_____
Address:_____ Date of Birth:_____
Home Phone:_____ Cell:_____ Work:_____
Employer:_____ Occupation:_____

___ Other Name:_____ E-mail:_____
Address:_____Date of Birth:_____
Home Phone:_____ Cell:_____Work:_____
Employer_____ Occupation:_____

Insurance Information

Dental Insurance Company:_____Phone:_____
Person Carrying Insurance:_____ID#_____Date of Birth__/___/___
Group #_____Address:_____

Second Insurance Company:_____ Phone:_____
Person Carrying Insurance:_____ID#_____Date of Birth__/___/___
Group #_____Address:_____

Have any other family members been seen at our office? If so, who:_____

PATIENT MEDICAL/DENTAL HISTORY

NAME_____ DATE OF BIRTH_____

PHYSICIAN / CLINIC_____DATE OF LAST PHYSICAL EXAM_____

DENTIST / CLINIC_____DATE OF LAST EXAM/CLEANING_____

1. List any current medical conditions or treatments.
2. List any major operations.
3. Explain any serious accidents involving head injuries.
4. List any drugs or medications, which you are currently taking.
5. List any drugs (incl. Penicillin), which have resulted in any adverse responses.
6. List any Allergies.
7. Explain any wounds which have healed slowly or presented other complications,
8. Are you currently pregnant?
9. Check any of the following of which you have a history:

_____A Heart Ailment
_____High Blood Pressure
_____Respiratory Disease
_____Diabetes
_____Rheumatic Fever
_____Thyroid Disorder
_____Cancer
_____Chemotherapy
_____Radiation Treatments
_____ Tumors or Growths
_____ Blood Disease
_____ Liver Disease
_____ Kidney Disease
_____ Stomach or Intestinal Disease
_____ Jaundice or Hepatitis
_____ AIDS
_____ Sexually Transmitted Disease

_____ Tobacco Use, If still using:
What type?_____How much?_____
_____ Chemical Dependency
_____ Eating Disorders
_____ Unexplained Weight Loss
_____ Fainting
_____ Night Sweats

ORAL CONCERNS:

_____ Growths or Sore Spots in Mouth
_____ Injuries to Mouth or Teeth
_____ Sensitive Teeth
_____ Clicking of Jaw Joints
_____ Locking of Jaw Joints
_____ Pain near or in Ears
_____ Shifting of Teeth
_____ Bleeding Gums
_____ Clenching of Teeth

OR _____NONE OF THE ABOVE

SIGNATURE OF PATIENT OR GUARDIAN_____TODAY'S DATE_____

UPDATE OF MEDICAL HISTORY-List any current medications or changes or updates to the above information:

UPDATE:_____

_____

Date _____ SIgnature_____

UPDATE:_____

_____

Date_____ SIgnature_____

UPDATE:_____

_____

Date _____ SIgnature_____