Date: _____

Chart # _____

Adult Information Form

WELCOME. To assist us in providing the most complete service, please provide the following information and health history.

Lisa A. Slingbaum, D.M.D.
Jamie T. Zupnik, D.M.D., M.S.
Specialist in Braces & Invisalign
for Children & Adults

7400 Northwest Fifth Street
Plantation, Florida 33317
954-797-4171
fax 954-581-9479
www.southfloridabraces.com

PERSONAL INFORMATION

Patient's Name _____

Address _____

City/State/Zip _____

Home Phone _____

Cell Phone _____

Email _____

Employed by _____

Occupation _____

Work Phone _____

Date of Birth _____

S.S.# _____

Dentist _____

Phone _____

Who referred you to our office? _____

What would you like to have orthodontic treatment accomplish? _____

_____

_____

MEDICAL HISTORY

Please check box if patient has or has had:

- ❑ Asthma
- ❑ Joint swelling
- ❑ Bone disorders
- ❑ Heart trouble
- ❑ Rheumatic fever
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Emotional problems
- ❑ Anemia
- ❑ Epilepsy
- ❑ Prolonged bleeding
- ❑ Faintness/Dizziness
- ❑ Tonsils removed
- ❑ Adenoids removed
- ❑ Sore throats
- ❑ Tonsillitis
- ❑ Earaches

List any other serious illnesses _____

_____

List any allergies _____

List drugs or medications now being taken _____

_____

Do you smoke or use tobacco presently? Yes No

Is patient under physicians care presently? _____

Reason _____

Name of Physician _____

_____

Person responsible for account _____

DENTAL HISTORY

Please check box if answer is yes:

- ❑ Any injuries to face, mouth, teeth? (circle)
- ❑ Thumb, finger, lip sucking? (circle)
- ❑ Mouth breathing when asleep, awake? (circle)
- ❑ More than average amount of decay?
- ❑ Any missing permanent teeth?
- ❑ Any teeth removed by extraction?
- ❑ Is there any tongue-thrusting problem?
- ❑ Any speech problems?
- ❑ Any difficult swallowing or chewing?
- ❑ Any pain or clicking on opening mouth?
- ❑ Does patient visit dentist regularly?

Date of last dentist visit _____

Has an orthodontist been consulted previously?

Reason: _____

_____

SPOUSE INFORMATION

His/Her Name _____

Cell Phone _____

Employer _____

Work Phone _____ Ext. _____

S.S.# _____ DOB _____

Please complete other side

Do you have concerns regarding possible orthodontic treatment?

q **Expense** q **Discomfort** q **Esthetics during Treatment**

q **Length of Treatment**

q **Other**

_____

_____

_____

_____

_____

Patient Authorization - PLEASE SIGN BELOW

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

X _____

Signature **Date**

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

X _____

Signature **Date**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

X _____

Signature **Date**