

DR. RONALD B. GROSS & DR. JOEL R. FROMER ASSOCIATES

ADULT

EXAM DATE: _____

PERSONAL HISTORY

PATIENT NO.: _____

Patient's Name: _____

Prefers to be addressed by: _____

Sex: M F

Age: _____

Birth Date: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Employer: _____

S.S.# _____

Home Ph.#: _____

Bus. Ph#: _____

Occupation: _____

 Married

 Single

 Divorced

 Separated

 Widowed

Spouse's Name: _____

S.S.#: _____

Address: () _____

Home Ph#: _____

Bus Ph#: _____

Employer: _____

Occupation _____

Emergency Contact: _____

Relationship: _____

Ph.#: _____

Responsible for Account: _____

Home Ph.# _____

Bus. Ph.# _____

Address: _____

DENTAL HISTORY

Patient's Dentist: _____

Address: _____

Referred By: _____

Date of Last Exam: _____

X-Rays Taken: _____

Do you now or previously? Suck Thumb /Fingers Bite Lip Snore Mouth Breathe Grind/Clench Teeth

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

Do you have any speech problems? Y N

Are there any lumps, sores or irritated areas in mouth? Y N Have you had any injuries to face, mouth, or teeth? Y N

Have you ever had: Orthodontic Treatment TMJ Problems Periodontal Disease

Main Concern _____

Has any family member ever had orthodontic treatment? Y N Names: _____

Has any family member ever been treated at our office? Y N Names: _____

MEDICAL HISTORY

Physician's Name & Address: _____

Patient's general health at this time Good Fair Poor

Date of last physical: _____

Are you under a physician's care or taking any medications at this time? Y N

List Medications: _____

Do you need to be pre-medicated prior to any dental treatment? Y N

List Medications: _____

Have tonsils and/or adenoids been removed? Y N

Your Height? _____

Weight? _____

Do you have any special or serious health problems not listed? Y N

If so, please list them: _____

CHECK ALL THAT APPLY

Y N HIGH BLOOD PRESSURE
 Y N LOW BLOOD PRESSURE
 Y N HEART MURMUR
 Y N MITRAL VALVE PROLAPSE
 Y N RHEUMATIC FEVER
 Y N FAINTING SPELLS
 Y N TONSILLITIS
 Y N EMOTIONAL PROBLEMS
 Y N HEADACHES

Y N RESPIRATORY PROBLEMS
 Y N TUBERCULOSIS
 Y N ARTHRITIS
 Y N CANCER
 Y N BLOOD DISORDERS/BLEEDING
 Y N HERPES (ORAL COLD SORES)
 Y N EARACHES
 Y N EPILEPSY
 Y N LIVER DISEASE

Y N ALLERGIES: MEDICINE
 Y N ALLERGIES: OTHER
 Y N ASTHMA
 Y N DIABETES
 Y N INFECTIOUS DISEASES
 Y N A.D.D.

OTHER: _____

ORTHODONTIC INSURANCE

Primary Insurance Co.: _____ Group #: _____ I.D.#: _____

Insured's Name: _____ S.S.#: _____ Birth Date: _____

Insured's Employer: _____ Ph. #: _____ Dental Flex/Cafeteria Acct: Y N

Secondary Insurance Co.: _____ Group #: _____ I.D.#: _____

Insured's Name: _____ S.S.#: _____ Birth Date: _____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION.

Signature of Parent or Guardian _____ Today's Date: _____
Update _____ Initial: _____
Update _____ Initial: _____

OFFICE USE ONLY

PRESENT: M F ALL RBG JRF STUDY Y N

INFORMED CONSENT BOOK GIVEN Y N REC'D Y N CERAMICS Y N

INSURANCE Y N INSURANCE FORM GIVEN Y N

COUPONS EXP. Y N STUDY _____ CONS _____ PAID _____

RECALL _____ mos. PENDING _____ mos. SUSPENSE _____ mos.

FEE RANGE _____ PAYMENT SCHEDULE _____

REFERRAL LETTER _____ Envelope Sent _____

NOTES: _____
