PACHTER
ORTHODONTICS

Adult New Patient Form **Date** _____

NAME _____ PREFERRED NAME _____

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Dr. BIRTHDATE _____ Gender: ☐Male ☐Female

ADDRESS **(Mailing)** _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

Appointment Reminders: Text Message # _____ and/or E-Mail _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMPLOYER_____ OCCUPATION _____ WORK PHONE _____

BUSINESS ADDRESS _____

S.S.# _____
(For accounting purposes only)

EMERGENCY CONTACT

SPOUSE/RELATIVES **NAME** _____ Relationship to patient _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

DENTAL INSURANCE INFORMATION ONLY

Insurance can only be verified with a Social Security number and Date of Birth

Primary Insurance

POLICY HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ DATE EMPLOYED _____

INSURANCE COMPANY _____ ID # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE PHONE# _____

Secondary Insurance

POLICY HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ DATE EMPLOYED _____

INSURANCE COMPANY _____ ID # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE PHONE# _____

PATIENT'S NAME _____

PATIENT'S DENTIST _____ Phone_____ Address _____

PATIENT'S PHYSICIAN _____ Phone_____ Address _____

PATIENT MEDICAL HISTORY

		YES	NO
1.	Are you under medical treatment now?	___	___
2.	Have you ever been hospitalized for any surgical operation or serious illness?	___	___
3.	Are you taking any medication(s) including Non-prescription medicine? If yes, what medication(s) are you taking?_____	___	___
4.	Do you use tobacco?	___	___
5.	Do you use alcohol, cocaine or other drugs?	___	___
6.	Are you wearing contact lenses?	___	___

7. Are you allergic to or have you had any reactions to **medications, latex** or **metals**?
(Eg: aspirin, penicillin, sulfa drugs, etc.) If yes,what?_____

8. Women ONLY:	Yes	No
a) Are you pregnant or think you may be pregnant?	___	___
b) Are you nursing?	___	___
c) Are you taking birth control pills?	___	___

*Please comment any other significant information about the patient's medical history:_____

Habits:

YES	NO	
( )	( )	Clenching/ Grinding Teeth
( )	( )	Lip Sucking
( )	( )	Mouth Breather
( )	( )	Nail Biting
( )	( )	Thumb/finger sucking
( )	( )	Nursing bottle habits

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive to hot or cold liquids/foods?	___	___
3. Are your teeth sensitive to sweet or sour liquids/foods?	___	___
4. Do you feel pain to any of your teeth?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___
6. Have you had any head, neck, or jaw injuries?	___	___
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking	___	___
b) Pain (joint, ear, side of face)?	___	___
c) Difficulty in opening or closing?	___	___
d) Difficulty in chewing?	___	___

	YES	NO
8. Do you have frequent headaches?	___	___
9. Do you clench or grind your teeth?	___	___
10. Do you bite your lips or cheeks?	___	___
11. Have any wisdom teeth been removed? How many?	___	___
12. Have you had any orthodontic work?	___	___
If yes, when_____		
If yes, doctor's name_____		
13. Have you ever had treatment for a periodontal disease (gum disease)?	___	___
14. Have your jaws ever "locked" CLOSED? If yes, describe_____	___	___
15. Have your jaws "locked" wide OPEN? If yes, describe_____		

GROWTH AND DEVELOPMENT

YES	NO	
___	___	Are there any learning disabilities? If yes, explain_____
___	___	Has any other member of the family had orthodontic treatment?_____
___	___	Has any other member of the family been a patient in this office? Name:_____

Please describe why you sought this consultation_____

*****We will be taking (2) x-rays and pictures at Orthodontic Appointment. Please check with patient's Dentist if a Panoramic Dental or Cephalometric x-ray was done with-in a year. If yes please bring to appointment or have them email to info@pachterortho.com.**

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

X_____ _____
(Signature of Responsible Adult) Date

Doctor'sNotes_____