Robert R. Mortimer, DMD

orthodontic specialist

Adult Patient Information

Date________________20________ Account Number________________
(For office use only)

Mr.____ Mrs. ____Ms.____ Dr._____

Patient's Name____
Last First M

Address:____

City______________________ State______ Zip_______________

Date of Birth_______________ Age_______________ Gender Female_____ Male_____

Doctor: **Dr. Mortimer** Office: **Plum/Murrysville Penn Hills Munhall Eliz. Twp.**
(please circle correct office)

Home Phone_________________Business Phone______________Cell Phone___________

E-Mail Address____________________________

Billing Party____________________________ Address if different_________________________
(who is financially responsible)

Do you have insurance that covers Orthodontic Treatment________YES ________NO

Referred by_________________ Family Dentist___________________ Phone No.____________

Contact Person______________________________________Phone No.____________________

Physician__________________ Oral Surgeon________________ Phone No.______________

Employed by____Phone_____________________

Occupation____ SS#_______________________

Dental Insurance_____________________________________Phone______________________

Spouse's Name______________________________________SS#________________________

Employed by____Phone______________________

Occupation____D.O.B.____________________

Dental Insurance_____________________________________Phone______________________

Names and ages of children____

Patient's Medical History

Is the patient in Good Health? ___yes___no
Height________Weight_________

Has the patient been treated for any of the following?

____Diabetes	____Tuberculosis	____Endocrine problems
____Pneumonia	____Heart Trouble/Murmur	____Anemia
____Prolonged bleeding	____Epilepsy	____Fainting/Dizziness
____Rheumatic Fever	____Asthma	____Nervous Disorders
____Bone Disorders	____Kidney/ Liver	____Frequent colds/sore throats/ ear prob.

Other:____
Present Medications:______________________________Allergy/Drug reactions______
Does the patient ever take any anti-inflammatory drugs? __________________________
Have the tonsils or adenoids been removed? _____yes_____no Date_______________
Onset of Puberty ____yes____no Date___________________
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Dental History

Have there been any injuries to the face, mouth, or teeth? ____yes _____no
Date_______________Explain____
Has the patient ever sucked a thumb, finger or pacifier?__yes __no Until what age? ____
Does the patient have any speech problems? ___yes ___no Explain______________
Is the patient a mouth breather? ____yes ____no
Have you been informed of any missing or extra permanent teeth? ____yes ____no
Does the patient have any of the following symptoms?

____Head or Neck pain	____Click, popping or grinding in the jaw joint	
____Ear pain	____Frequent headaches	____Jaw locking

Does the patient play sports?_________________a musical instrument?____________
Has an Orthodontist been consulted previously? ___yes ___no Date_______________
In your own words what do you see as the problem?____________________________
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Parent/Patient Signature