Robert R. Mortimer D.M.D.

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 _____

Home Phone _____ Business Phone _____ Cell Phone: _____

Email: _____

Occupation _____ Employed by _____

Referred by _____ Family Dentist _____

Primary Care Physician _____ Oral Surgeon _____

Billing Party _____ Address _____
(who is financially responsible)

Primary Dental Insurance Carrier _____Member ID _____

Policy holders name _____ Relationship _____

Date of Birth _____ Social Security # _____

Secondary Dental Insurance Carrier _____Member ID _____

Policy holders name _____ Relationship _____

Date of Birth _____ Social Security # _____

Name and ages of children _____

MEDICAL HISTORY

Is the patient in good health ? ____ Yes ____ No

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 throat/ear problems
__ Autism

Other _____ Allergy/Drug reactions _____

Does the patient regularly take any anti-inflammatory drugs? __ Yes __ No (Advil, Ibuprofen, Celebrex)

Current medications? _____

Have the tonsils or adenoids been removed? __ Yes __ No Date _____

Does your child snore? __ Yes __ No Is your child a mouth breather? __ Yes __ No

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? __ Yes __ No
Date of injuries _____ 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 _____
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 _____ Who _____

In your own words, what do you see as the problem? _____
_____

I consent to any and all diagnostic procedures and orthodontic treatment provided by Dr. Mortimer, assistants, or other personnel. I release any information concerning my (my child's) health care, advice and treatment to another dentist for evaluating and administering treatment. I authorize payment of any dental benefits to Dr. Mortimer for services rendered.

Signature _____ Date _____