Embrace ORTHODONTICS

PATIENT INFORMATION - ADULT

Date _____

Title _____ Legal Name _____

Preferred Name _____ DOB _____ Gender _____

E-Mail Address _____ Marital Status/Spouse's Name _____

Address _____

Phone 1 _____ (Home/Cell/Work) Phone 2_____ (Home/Cell/Work)

Employer _____ Occupation _____

Hobbies/Interests _____

How did you hear about our practice? _____ General Dentist _____

Past or Present Family Members in Treatment _____

Have you Consulted an Orthodontist Before? _____

INSURANCE INFORMATION

Subscriber's Name _____ DOB _____

Address _____ Phone _____

Employer _____

Insurance Company _____ Phone _____

Group Number _____ Subscriber ID/SS# _____

Signature _____ Date _____

Embrace Orthodontics
13185 St. Croix Ave • Lindstrom, MN 55045
(651) 257-4445 • www.embracemn.com

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MEDICAL HISTORY

Patient's Name _____ Date _____

Dentist's Name _____ Date of Last Dental Exam _____

Physician's Name _____ Date of Last Physical Exam _____

Allergies or reactions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotics
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other _____

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past, has the patient had:

Y __ N __ Adenoids or tonsils removed
Y __ N __ Arteriosclerosis (hardening of the arteries)
Y __ N __ Asthma, hay fever, sinus trouble or hives
Y __ N __ Autoimmune disorders or immune system problems
Y __ N __ Bleeding or bruising easily
Y __ N __ High or low blood pressure – please circle
Y __ N __ Cancer, tumor, chemotherapy or radiation treatment
Y __ N __ Chronic fatigue
Y __ N __ Current pregnancy
Y __ N __ Depression or other mental health disturbance
Y __ N __ Diabetes
Y __ N __ Dizziness
Y __ N __ Epilepsy or other seizure disorder
Y __ N __ Fibromyalgia
Y __ N __ General anesthesia
Y __ N __ Hearing impairment
Y __ N __ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y __ N __ Frequent coughs, colds or sore throats
Y __ N __ Hemophilia
Y __ N __ Hepatitis, AIDS or HIV positive
Y __ N __ Injury to face, neck, mouth or teeth – please circle
Y __ N __ Insomnia
Y __ N __ Jaw joint surgery
Y __ N __ Kidney or liver problems
Y __ N __ Meniere's disease
Y __ N __ Multiple sclerosis
Y __ N __ Muscular dystrophy
Y __ N __ Nighttime breathing problems (snoring or sleep apnea)
Y __ N __ Nervousness
Y __ N __ Neuralgia
Y __ N __ Osteoarthritis (stiff or swollen joints)
Y __ N __ Osteoporosis
Y __ N __ Parkinson's disease
Y __ N __ Prior orthodontic treatment
Y __ N __ Psychiatric care
Y __ N __ Rheumatic fever
Y __ N __ Rheumatoid arthritis
Y __ N __ Scarlet fever
Y __ N __ Skin disorder
Y __ N __ Speech difficulties
Y __ N __ Stroke or heart attack
Y __ N __ Tuberculosis
Y __ N __ Wisdom teeth extraction
Y __ N __ Birth defects or hereditary problems
Y __ N __ Endocrine or thyroid problems
Y __ N __ Stomach ulcer or hyperacidity
Y __ N __ Polio, mononucleosis or pneumonia
Y __ N __ Vision problems
Y __ N __ Loss of weight recently, poor appetite
Y __ N __ Eating disorder (anorexia or bulimia)
Y __ N __ Chest pain, shortness of breath or swelling ankles
Y __ N __ Frequent or severe headaches
Y __ N __ Other condition

Emergency Contact _____ Relationship _____ Phone # _____

Patient/Parent Signature _____ Today's Date _____

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