Adult Consult Request

*Required Fields must be filled out accordingly, in order to successfully submit the form.

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*First Name:

*Last Name:

I prefer to be called:

*Date of Birth:

*Mailing Address:

*Home Phone:

Cell Phone:

Home Email:

Do you have orthodontic insurance? ☐ yes ☐ no ☐ not sure

Name of Employer:

Business Phone:

Business Email:

***PREFERRED FORM OF CONTACT:**

☐ Home Phone ☐ Home Email ☐ Business Phone ☐ Business Email ☐ Cell Phone

FINANCIALLY RESPONSIBLE PARTY (if different from above)

*First Name:

*Last Name:

*Relationship to patient: ☐ mother ☐ father ☐ other

Other relative, please explain:

*Mailing Address:

*Home Phone:

Cell Phone:

Home Email:

Do they have orthodontic insurance? ☐ yes ☐ no ☐ not sure

Name of Employer:

Business Phone:

Business Email:

GENERAL INFORMATION

How did you hear about our office?

Who may we thank for referring you?

Family Dentist:

Family Physician:

MEDICAL HISTORY

Do you have allergies? □ yes □ no

If yes, please indicate what the allergy is:

Do you have a heart condition requiring antibiotics before dental procedures? □ yes □ no □ not sure

If yes, please explain:

Have you been hospitalized in the last year? □ yes □ no

If yes, please explain:

Are you currently taking medication? □ yes □ no

If yes, please explain:

Do you have any muscle or arthritis problems? □ yes □ no

If yes, please explain:

Do you suffer from snoring or sleep apnea? □ yes □ no

If yes, please explain:

Do you have any tonsil or adenoid problems? □ yes □ no

If yes, please explain:

Please explain any other medical problems:

DENTAL / ORTHODONTIC HISTORY

Are you aware of any of the following problems:

Thumb or finger habit □ yes □ no

Mouth breathing □ yes □ no

Speech problems □ yes □ no

Tongue thrust □ yes □ no

Have you been evaluated for orthodontic treatment in the past? □ yes □ no

If yes, by whom and when?

Have you had orthodontic treatment in the past? □ yes □ no

If yes, by whom and when?

Have you had periodontal (gum) treatment? □ yes □ no

If yes, by whom and when?

Have you ever had any injuries to your teeth? ☐ yes ☐ no
If yes, please explain?

Are you happy with your smile? ☐ yes ☐ no
If not, what would you change?

Are you happy with the profile of your face and/or bite? ☐ yes ☐ no
If not, what would you change?

JAW PAIN / TMJ HISTORY

Are you currently wearing a biteplane or night guard? ☐ yes ☐ no

Have you ever worn a biteplane or night guard
in the past? ☐ yes ☐ no

Do you or have you ever experienced jaw pain? ☐ yes ☐ no
If yes, please explain:

Have you been treated for jaw pain or TMJ? ☐ yes ☐ no
If yes, please explain:

Have you ever received a blow/trauma to your jaw? ☐ yes ☐ no
If yes, please explain:

Have you experienced any of the following issues:

Grind your teeth ☐ yes ☐ no
Clench your teeth ☐ yes ☐ no
Noise in the joint when opening/closing ☐ yes ☐ no
Jaw locking open/closed ☐ yes ☐ no
Ringing/fullness in the ears ☐ yes ☐ no
Headaches ☐ yes ☐ no

PERSONAL

What extra-curricular activities or hobbies
do you enjoy?

Do you participate in sports? If so, which ones?

Is there anything else you would like to add?

Do you have any friends or family that are undergoing treatment or have had treatment at our office? ☐ yes ☐ no

Family member's name(s):

Friend's name(s):

How was their overall experience?

☐ excellent ☐ good ☐ fair ☐ not sure

Do you have any friends or family who may also be interested in a consultation? ☐ yes ☐ no

First Name:

Last Name:

Home Phone:

Email:

*****If you refer a friend or family member for a consultation, your name is entered into our monthly referral draw to win a prize. If that friend or family member starts his/her treatment with us, you will receive a $100.00 referral gift!**