ENCINITAS ORTHODONTICS
Torin L. Chenard, DDS

ADULT PATIENT INFORMATION FORM

Welcome to our office...
Please assist us by completing the following questions...

Date of exam _____ 20____
Date of birth _____

Patient's name _____ Soc. Sec. No. _____ Age _____ Sex _____
LAST FIRST INITIAL

Res. address _____ Phone _____

Marital status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Patient's dentist _____ Referred by _____

Physician _____

Names of other members of your family treated by our office _____

Person responsible for account _____ Soc. Sec. No. _____

Address _____ City _____ Zip _____

Contact E-mail address: _____

Do you have an insurance plan which covers orthodontic treatment? ☐ Yes ☐ No Name of company _____

Occupation _____ Bus. telephone _____

Employed by _____

Spouse's name _____ Soc. Sec. No _____ Bus. telephone _____

Employed by _____ Occupation _____

MEDICAL HISTORY

	YES	NO	?
Are you in good health?	☐	☐	☐
Do you have any history of major illness?	☐	☐	☐

Check any of the following for which you have been treated:

DIABETES ☐	BONE DISORDERS ☐	EPILEPSY ☐	PROLONGED BLEEDING ☐
PNEUMONIA ☐	HEPATITIS ☐	ASTHMA ☐	LIVER INVOLVEMENT ☐
HEART TROUBLE ☐	TUBERCULOSIS ☐	KIDNEY INVOLVEMENT ☐	FAINTING & DIZZINESS ☐
RHEUMATIC FEVER ☐	ANEMIA ☐	ENDOCRINE OR THYROID ☐	NERVOUS DISORDERS ☐

List any drugs or medications now being taken. Give reasons. _____

Do you have arthritis?	☐	☐	☐
List any allergies or drug sensitivity: _____			
Have wisdom teeth been removed? Yes ☐ No ☐ At what age? _____			
Have you seen a physician in the last 2 years?	☐	☐	☐
Do you smoke or use tobacco? Yes ☐ No ☐			

DENTAL HISTORY

	YES	NO	?
Have there been any injuries to the face, mouth or teeth?	☐	☐	☐
Do you have any problems with your speech?	☐	☐	☐
Do you breath predominantly through your mouth?	☐	☐	☐
Do you have frequent headaches?	☐	☐	☐
Have you had any clicking or discomfort in jaw joints near ears?	☐	☐	☐
Have you been informed of any missing or extra permanent teeth?	☐	☐	☐
Have you had any previous orthodontic examinations? Yes ☐ No ☐ If so, how long ago? _____			
Do you clench or grind your teeth?	☐	☐	☐
Have you had any periodontal treatment?	☐	☐	☐
Do you feel that you need orthodontic treatment?	☐	☐	☐
When did you last visit your dentist? _____ Where any x-rays taken? _____	☐	☐	☐

How would you like your problem corrected? Braces ☐ Invisalign ☐ _____

List sports and interests: _____

Reason for today's visit: _____

How did you hear about our office? _____

_____
Signature

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Certified Invisalign Provider • Orthodontics for Children and Adults

Member American Association of Orthodontists