CULVER CITY ORTHODONTICS
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Orthodontic Patient Intake Form – Adult

Patient Information

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Preferred Pronouns *(optional)*: _____

Phone #: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Employer: _____ Marital Status: _____

Who may we thank for referring you to our office? _____

Spouse/Additional Contact Information

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Age: _____ Sex: _____ Preferred Pronouns: _____

Phone #: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Employer: _____

Dental Insurance Information

Insured Name: _____ Insured SS#: _____ Insured Date of Birth: _____

Insurance Company: _____ Insurance Member ID: _____ Group #: _____

Insurance Company Address: _____

Phone: _____ Insured's Employer: _____

(If you have dual coverage, complete section below)

Insured Name: _____ Insured SS#: _____ Insured Date of Birth: _____

Insurance Company: _____ Insurance Member ID: _____ Group #: _____

Insurance Company Address: _____

Phone: _____ Insured's Employer: _____

Medical History Information

Which best describes your general health? *(Circle one)* Excellent Good Fair Poor
Last Dental Visit *(date and reason for visit):* _____
Name/phone # of your regular dental provider: _____
Name/phone # of your physician: _____
Do you have a history with any of the following systemic conditions? *(Circle one for each)*

1) Heart/Cardiovascular conditions Yes No
   (e.g. heart defect, artificial valve)
   If "Yes," please explain:
2) Lung/Respiratory conditions Yes No
   (e.g. Asthma, emphysema)
   If "Yes," please explain:
3) Bleeding Disorders Yes No
4) Immune Deficiency or HIV Yes No
   If "Yes," please explain:
5) Autoimmune Disease Yes No
   (Rheumatoid Arthritis, Lupus, etc.)
6) Cancer/Radiation/Chemotherapy Yes No
7) Organ Transplant Yes No
8) Diabetes Yes No
9) Liver Disease Yes No
10) Renal Dialysis/Kidney Disease Yes No
11) Arthritis/Painful Joints Yes No
12) Artificial Joints Yes No
13) Osteoporosis Yes No
14) Seizures/Epilepsy Yes No
15) Numbness/Tingling/Paralysis Yes No
16) Muscle Weakness/MS Yes No
17) Depression/Anxiety Yes No
18) ADD/ADHD Yes No
19) Cognitive Impairments Yes No
    If "Yes," please explain:
20) Other Psychiatric Conditions Yes No
    If "Yes," please explain:
21) Other medical conditions? Yes No
    If "Yes," please explain:

Do you have any of the following allergies?

Penicillin	Yes	No	Latex	Yes	No	Other	Yes	No
Sulfa Drugs	Yes	No	Nickel/Metals	Yes	No	*(please specify)*		

Have you ever been hospitalized?..... Yes No
If "Yes," please explain:

Do you require antibiotic prophylaxis before dental treatment?..... Yes No

Have you ever taken intravenous bisphosphonate medication, such as
Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?..... Yes No

Have you ever taken oral bisophosphonate medication?
Such as Fosamax (alendronate), Actonel (ridendronate),
Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?..... Yes No

Are you currently pregnant or breastfeeding? ..... Yes No

Please list all current medications: _____

_____

Patient Signature: _____ **Date:** _____

(If someone other than patient is signing) Relationship to Patient: _____

Orthodontic Specific Questions

What are your personal goals for orthodontic treatment and what, if anything, would you like to change about your smile or appearance?

What specific questions/concerns do you want to make sure the doctor addresses today?

Have you had any previous orthodontic treatment?..... Yes No
If "Yes," please explain:

Have you been to another orthodontist for a consultation?..... Yes No
If "Yes," please explain:

Have you had negative experiences in a dental office in the past?..... Yes No
If "Yes," please explain:

Do you have any sensory issues/gag reflex we should be aware of?..... Yes No
If "Yes," please explain:

Do you have a history of orthodontic problems in your family (e.g. underbite, crossbite)?..... Yes No
If "Yes," please explain:

Is there any history of craniofacial anomalies (cleft lip, cleft palate, etc.) in your family?..... Yes No
If "Yes," please explain:

Have you had any injury to the head, neck, jaws, or teeth?..... Yes No
If "Yes" please explain:

Do you have jaw pain or difficulty opening/closing your jaw?..... Yes No

Do you have a history of long-term oral habits (e.g. finger/thumb sucking, biting pens)?.....Yes No

Do you have recurrent poor sleep, snoring, daytime sleepiness?..... Yes No
(If "Yes") Have you ever been diagnosed with Obstructive Sleep Apnea?..... Yes No