PLEASE PRINT

ADULT EXAMINATION

DATE ____________

PATIENT

NAME ________ FIRST ________ MIDDLE ________ LAST ________ NICKNAME ________

MALE ☐ FEMALE ☐ AGE ________ BIRTHDATE ________ (MONTH DAY YEAR) PHONE ________

ADDRESS ________ NUMBER AND STREET ________ CITY ________ ZIP ________

SINGLE ☐ MARRIED ☐ DIVORCED ☐ CHILDREN ________

EMPLOYED BY ________ POSITION ________

ADDRESS ________ PHONE ________

SPOUSE

FIRST NAME ________

EMPLOYED BY ________ POSITION ________

ADDRESS ________ PHONE ________

PERSON RESPONSIBLE FOR THIS ACCOUNT ________ INS. ________

PATIENT'S DENTIST ________ PHYSICIAN ________ REFERRED BY ________

DENTAL HISTORY

	YES	NO
Has the patient ever sucked thumb or fingers?	☐	☐
Does the patient breathe predominantly through the mouth?	☐	☐
Have you been informed of any missing permanent teeth?	☐	☐
Have you been informed of any extra teeth?	☐	☐
Have any teeth been injured due to accidents or falls?	☐	☐
Has the patient had any severe head or facial injuries?	☐	☐
Is the patient especially apprehensive toward dental visits?	☐	☐
Any jaw clicking or popping?	☐	☐

LIST ANY DRUGS OR MEDICATION NOW BEING TAKEN:

MEDICAL HISTORY

Check any of the following for which the patient has been treated:

Diabetes	☐	Emotional Problems	☐
Rheumatic Fever	☐	Kidney Problems	☐
Heart Trouble	☐	Eye Problems	☐
Anemia	☐	Allergies to Drugs	☐
Epilepsy	☐	Hepatitis	☐
Asthma	☐	Arthritis	☐
Hay Fever / Allergies	☐	Immune System Disorder	☐
Abnormal Bleeding	☐	(AIDS, HIV, ARC)	☐
Fainting or Dizziness	☐	Other Serious Disorders	☐
Tuberculosis	☐		