Doctors Circle
910 251-1100

Porters Neck
910 251-1100

ortho@campbellsmiles.com
candcorthodontics.com

CAMPBELL COVINGTON ORTHODONTICS

Adult History

Today's Date: _____

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

Name: _____ SS #: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❒ Male ❒ Female Birthdate: ___/___/___ Age: _____

Home Address: _____
APT / CONDO # CITY STATE ZIP

Hm #: _____ Wk #: _____ Cell #: _____ Email: _____

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Employer: _____ How long there? _____

Employer's Address: _____

Occupation: _____ Where & when are best times to reach you? _____

Whom may we Thank for referring you to our office? _____

Other family members seen by us: _____

General Dentist: _____ Last Visit Date: ___/___/___

Spouse's Name: _____ SS #: _____ Birthdate: ___/___/___

Employer: _____ Wk #: _____ Ext: _____

Person Responsible for Account: _____ SS #: _____
(if different from above)

Billing Address: _____

Relation: _____ Wk #: _____ Ext: _____ Hm #: _____

Employer: _____

Orthodontic Insurance

Name & Address of Insurance Company: _____ Phone #: _____

Insurance Address: _____

Subscriber ID #: _____ Group #: _____

Subscriber Name: _____ SS #: _____ DOB: ___/___/___

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

Medical History

Do you have a personal physician? ❒ Yes ❒ No Date of Last Visit: ___/___/___

Physician Name: _____ Phone #: _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor Are you currently under the care of a physician? ❒ Yes ❒ No

Please explain: _____

Are you taking any prescription / over-the-counter drug? ❒ Yes ❒ No

Please list each one: _____

Are you pregnant? ❒ Yes ❒ No Week #: _____

(CONTINUED ON BACK)

Have you ever had any of the following diseases or medical problems?
(Please check all that apply)

_____ Allergic to Latex / Metals
_____ Anemia
_____ Asthma
_____ Cancer / Chemotherapy
_____ Congenital Heart Defect
_____ Diabetes
_____ Difficulty Breathing
_____ Emphysema
_____ Epilepsy / Seizures / Fainting Spells
_____ Heart Attack/Stroke
_____ Heart Murmur
_____ Heart Surgery / Pacemaker
_____ Hemophilia / Abnormal Bleeding
_____ Hepatitis
_____ High / Low Blood Pressure
_____ HIV + / AIDS
_____ Kidney Problems
_____ Mitral Valve Prolapse
_____ Scarlet Fever
_____ Severe / Frequent Headaches
_____ Sinus Problems

Please list any serious medical condition(s) that you have ever had: _____

Please list any drugs that you are allergic to: _____

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Have you ever been evaluated for orthodontic treatment? ❒ Yes ❒ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you need Pre-medication prior to dental visits? ❒ Yes ❒ No

Do you now or have you ever experienced pain / discomfort in you jaw joint (TMJ / TMD)? ❒ Yes ❒ No

Your current dental health is: ❒ Good ❒ Fair ❒ Poor Do you like your smile? ❒ Yes ❒ No

Do your gums bleed? ❒ Yes ❒ No Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you smoke? ❒ Yes ❒ No

Do you have any speech problems? _____

Do you generally breathe through your mouth: ❒ Yes ❒ No Awake? ❒ Yes ❒ No Asleep? (Please Circle)

Do you have any missing or extra permanent teeth? ❒ Yes ❒ No

- This office reserves the right to verify the credit status of potential patients and/or parents or patients prior to extending credit for treatment fees.
- I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
SIGNATURE DATE

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History

Findings: _____

_____

_____

Recommendations: _____

_____

_____