Stephanie Cornejo DDS
ORTHODONTICS

Adult History Form

Full Name: _____ Like to be called: _____ Sex: M F Age: _____ Birthdate: _____

Address:_____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Employer: _____ Occupation: _____

Responsible Party: _____ Phone number of responsible party:_____

Address of responsible party: _____ Email: _____

Whom may we thank for referring you to our office? _____Family we have seen: _____

Yes No Are you in good health?
Yes No Do you have any medical condition? What? _____
Yes No Do you take any medicine? What? _____
Yes No Do you have any allergies to medicines, latex, or nickel? What? _____
Yes No Have you ever had any surgery or hospitalizations? For what? _____

Physician's Name: _____

Do you have, or have you ever had any of the following:

Yes	No	Heart Disease	Yes	No	Hepatitis	Yes	No	Allergy to latex
Yes	No	Rheumatic fever	Yes	No	HIV/AIDS	Yes	No	Allergy to Nickel
Yes	No	Heart Murmur	Yes	No	Do you smoke?	Yes	No	Osteoporosis / Bone Cancer Medicine
Yes	No	Mitral Valve Prolapse	Yes	No	Allergies/ Hayfever			

Dentist: _____ Last dental visit: _____

Yes No Have there been any injuries to the face, mouth, or teeth? _____
Yes No Have you ever sucked a thumb or finger? Until what age? _____
Yes No Any missing or extra permanent teeth? _____
Yes No Has an orthodontist been consulted previously? Who? _____
Yes No Do you clench or grind the teeth at night? _____
Yes No Do you have a click or pop of the jaw joint? _____
Yes No Do you have or ever had any jaw pain? _____
Yes No Do you have gum disease or had any previous gum treatment? _____

What are your primary concerns? _____

I, the undersigned, have given the information, have reviewed it, and find it accurate and complete. I consent to the use of photographs for marketing/educational purposes.

Signature: _____ Date: _____