ADULT ORTHODONTIC INTAKE FORM

Please Note

- Regular visits to your dentist must continue during orthodontic treatment.
- Some appointments will infringe on school time or work.

PATIENT INFORMATION

Name Jason Burne	**Date of Birth** 2021/02/03	**Gender** Female
Address 1234 Main Street New Westminster, British Columbia VVV777 Cambodia	**Phone** 555-555-5555 **Email** lillaorvath@hotmail.com	
Would you like email reminders for appointments? Yes		
Occupation Electrician	**Employer** Electric Company	
Phone (Work) 555-555-5555		

DENTAL INFORMATION

Dentist's Name Karen Carpenter	**Referral Source** My mother is one of your patients
Do you have dental insurance covering orthodontics? Yes	
Reason for Consultation Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua. Neque convallis a cras semper auctor neque vitae tempus. Cursus sit amet dictum sit amet.	

MEDICAL HISTORY

Have you or have you ever had any of the following?

- [X] Rheumatic Fever
- [ ] Diabetes
- [ ] Chronic kidney problems
- [ ] Lung problems
- [ ] Epilepsy
- [ ] Prolonged bleeding
- [ ] Heart problems
- [ ] Liver problems

When was your last dental checkup and cleaning? 2021-02-02

List any allergies

svfdsvbadfb

bgn,mys

List any medical problems

gnsfhnmm

fgnhmtetm

List any medications you are currently taking

Name	Dosage	Frequency
gnbssh	shnmghm	smhm
fnshm	shnmshm	ghmdsgmhj

Do you play any musical instruments? Yes

What instruments do you play? Flute and french horn

Do you have any of the following habits?

- [X] Thumb/sooth sucking
- [ ] Nail biting
- [ ] Grinding teeth at night
- [ ] Mouth breathing
- [ ] Snoring

Has any member of the family had any orthodontic treatment? Yes

Have you had any previous orthodontic consults or treatment? Yes

Do you smoke or chew tobacco? Yes

For women, are you pregnant? Yes

CONSENT & SIGNATURE

✔ I consent to allowing the clinic to report any findings to my dentist or any other dental professional as they deem necessary. I also give permission for any records made in the process of examination, treatment and retention to be used for purposes of research, education or publication in professional journals.

Signature