

WELCOME TO DR. INGRAHAM'S OFFICE

Patient Information

A B C

Date: _____ Male Female

Full Legal Name: _____ Preferred Name: _____

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

Marital Status: Single Married Divorced Widowed Birthdate: _____

Residence: _____
Street City State Zip Code

Mailing Address: _____
(if different)

How long at this address: _____ Home Phone: _____ Work Phone: _____

Previous Address: _____
(if less than 3 years)

Employer: _____ Number of Years Employed: _____
(Name of Business if Self Employed)

Occupation: _____ Social Security Number: _____

Spouse's Name: _____ Birthdate: _____

Employer: _____ Occupation: _____ Number of Years Employed: _____

Work Phone: _____ Social Security Number: _____

If Applicable: Self Spouse

Active Duty Military Information: Rank/Rate _____ Duty Station _____ Retirement or Rotation Date _____

Primary Insurance		Secondary Insurance	
Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Person's Name under which coverage is carried: _____		Person's Name under which coverage is carried: _____	
Employer: _____		Employer: _____	

Please allow us to make a copy of your insurance card.

Emergency Information

Name of nearest relative not living with you _____

Complete Address: _____
Street City State Zip Code

Phone Number: (_____) _____

This office reserves the right to verify the credit status of potential patients prior to setting up financial arrangements.

Signature Date

Update (date & initial) _____ Update (date & initial) _____

Patient's Name _____ Age _____

Musical Instrument(s) currently playing _____

Personal Interests or Hobbies _____

Name & Ages of Children _____

Dental History

Patient's Dentist _____ Last Exam _____

Is there dental work or gum treatment needed or in progress? Yes No

Have you been to an orthodontist before? Yes No

Have any immediate family members had orthodontic treatment? Yes No

What are your main concerns about your teeth? _____

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Have you had a serious injury to your face, mouth, or teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any discomfort when opening/closing your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have missing or extra teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a negative reaction to dental care?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench/grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Medical Doctor _____ Last Exam _____

Under care of doctor now? Yes No Medications being taken: _____

Have you experienced

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to metals	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to latex/plastic	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>

Is antibiotic premedication required before dental procedures? Yes No

Please list any medical problems you have that might have an effect on your treatment in our office: _____

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

History given by: _____ Signature _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient.

Initials _____ Date _____

Comments: _____

MEDICAL HISTORY UPDATE

I have reviewed my dental and medical history and confirm that it is current and complete.

Signature Date

Signature Date

Signature Date