Inman & Baldwin Orthodontics

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207 Professional Park Dr. • Glasgow, KY 42141 • (270)651-9386
105 Medical Park Drive • Campbellsville, KY 42718 • (270)789-4542

Date ____________

ADULT PATIENT INFORMATION

Patient's Name________________________ Prefers to be called______________ Birthdate_________ Age____ Sex___
Address_________________________________ City /State_______________________ Zip Code__________
Home Phone__________ Cell Phone__________ Cell phone carrier__________ Email______________________
Would you like to receive appointment reminders by text or email? Text- Yes No Email- Yes No
Patient Social Security #____________________

Employed by ______________________________ Occupation ________________________________
Work Address ______________________________________Work Phone____________________________

Please circle: Single Married Divorced Separated Widowed

Spouse's Name ____
Employed by ______________________________ Occupation ________________________________
Work Address______________________________ Work or Cell Phone__________________________

Relatives treated here and their relationship to the you______________________________________
____

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

Patient's Dentist____

INSURANCE INFORMATION

Do you have Orthodontic Insurance ? Yes ☐ No ☐ If yes complete the following:

Insured's Name ______________________________ Social Security # ____________ Birthdate__________
Insurance Company ___________________________ID # __________________ Group# ______________
Insurance Company Address ____
Insurance Company Phone Number____
Insured's Employer ____

EMERGENCY INFORMATION

Name of nearest relative not living with you ____

Complete Address ______________________________________ Phone ____________________________

I understand that, where appropriate, credit bureau reports may be obtained and will be kept confidential.

Signature____

CONTINUED ON BACK

DENTAL HISTORY

Dentist's Name ______________________________ Do you receive regular dental checkups? ☐ yes ☐ no
Last dental exam ________________________ Last dental x-rays ___________________________________

Have you received any previous orthodontic consultation or treatment? __________________________________
How often do you brush your teeth?______________________Is floss used?_________How often?___________

Do you currently have, or have you ever had any of the following?

- Y N Periodontal disease
- Y N Gum surgery
- Y N Root canals, crowns or bridges
- Y N Any clicking, popping or pain of jaw, joints (TMJ)
- Y N Any missing or extra permanent teeth
- Y N Trouble chewing
- Y N Any past facial or mouth injuries What?____

What are you or your Dentist most concerned about? (purpose of visit)_____________________________________
____

ORAL HISTORY

The following are some habits commonly found which may influence tooth position. List info as pertains to you:

Y N Thumb sucking / until age _______ Y N Finger sucking / until age _______
Y N Nail biting Y N Mouth breather Y N Grinding of teeth
Other habits____

Have you ever had any speech therapy? Y N List any musical wind instruments played_____________________

Do you sleep on ☐ side ☐ back or ☐ face down

HEALTH HISTORY

Have you been under the care of a physician during the past 2 years? (other than routine checks) ☐ yes ☐ no
If yes, what for? ____

Are you currently taking any medications ? Y N If yes, please list ___________________________________
Have you ever taken any Bisphosphonates(Didronel, Skelid, Fosomax, Actonel, Boniva,Aredia, Zometa)? Y N
If yes, please list____

Are you allergic to anything (drugs, food, pollen,etc.)? ____

Do you currently have, or have you ever had any of the following?

Y N Tonsils removed	Y N Epilepsy/Seizures	Y N Nasal airway problems
Y N Adenoids removed	Y N Asthma	Y N Sinus problems
Y N Heart problems	Y N Bleeding problems	Y N Speech problems
Y N Diabetes	Y N High blood pressure	Y N Arthritis
Y N Anemia	Y N Immune disorders	Y N Tobacco usage
Y N Pneumonia	Y N Lung problems	Y N Respiratory problems
Y N Hepatitis	Y N Tuberculosis	

Do you have any *special* problems not listed above?____
____