Alexandria Orthodontics
Welcome Form
For Adults

CONFIDENTIAL

Tell Us About Yourself:

Today's Date:_____

Patient Name:_____ _____ **Birthdate :**_____
Last **First** **Middle Initial** **Preferred Name** **Age:**_____

Home Address: _____ **Sex:** ☐ Male ☐ Female

City_____ **State**_____ **Zip:** _____
Home Phone (_____) _____ **Cell Phone (_____)** _____
Email Address:_____ **SSN:** _____
Whom may we thank for referring you?_____
In Case of an Emergency, who should we notify? _____ **Phone (____)**_____

Spouse Information
Name: _____ **Title:** ☐ Mr ☐ Dr ☐ Other _____
Address (if different from above): _____
Home # (_____) _____ **Cell # (_____)** _____ **Business # (_____)** _____
Email Address: _____ **Occupation:** _____

About Your Employer
Company Name:_____ **Address:**_____ **Telephone: (___)**_____
How long have you been employed with them?_____ **Occupation:** _____

Responsible Party: ☐ Check if same as above

Name:_____
Billing Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____
Work Phone:_____ **Cell Phone:**_____

Insurance:

Primary Insurance
Primary policy holder's full name _____**Birthdate:**_____
Social Security # _____ **Relationship to patient** _____
Address and phone (if not listed above) _____
Employer: _____ **Address:** _____
Insurance Company: _____ **Group # :**_____ **ID#:** _____
Does this policy have benefits? ☐Yes ☐No ☐ Don't Know

Secondary Insurance
Secondary policy holder's full name _____**Birthdate:**_____
Social Security # _____ **Relationship to patient** _____
Address and phone (if not listed above) _____
Employer: _____ **Address:** _____
Insurance Company: _____ **Group # :**_____ **ID#:** _____
Does this policy have benefits? ☐Yes ☐No ☐ Don't Know

Dental History

What brings you to the Orthodontist today?

_____

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

Is your water fluoridated ☐ Yes ☐No

Are you taking fluoridated supplements ☐ Yes ☐No

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD) ☐ Yes ☐No

Floss your teeth daily ☐ Yes ☐No

Health History:

Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Congenital Heart Defect
☐	☐	Cancer	☐	☐	Convulsions/ Epilepsy
☐	☐	Rheumatic Fever	☐	☐	Abnormal Bleeding
☐	☐	HIV+/AIDS	☐	☐	Hearing Impairment
☐	☐	Hemophilia	☐	☐	Any Operations
☐	☐	Asthma	☐	☐	Any stays in Hospital
☐	☐	Hepatitis	☐	☐	Kidney/Liver Problems
☐	☐	Tuberculosis	☐	☐	Handicaps/Disabilities
☐	☐	Prosthesis	☐	☐	Allergies to Any drugs
☐	☐	Nickel Allergy	☐	☐	History of Scarlet Fever
☐	☐	Diabetes	☐	☐	Latex sensitivity/Allergies

Are you currently under the care of a physician?

☐ Yes ☐No

Explain:_____

Primary Doctor's Name:_____

Please describe your health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs you are currently taking:

_____

Please list all drugs that you are allergic to:

_____

For Women only:

Are you taking birth control pills? ☐ Yes ☐No

Are you pregnant? ☐ Yes ☐No

Are you nursing? ☐ Yes ☐No

I understand the information that I have given is correct to the best of my knowledge, that it 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: _____

Office Use Only --- Office Use Only --- Office Use Only --- Office Use Only

I verbally review the medical / dental information above with the parent/ guardian & patient named herein.

Initials: _____ Date: _____

Doctor's comments: _____