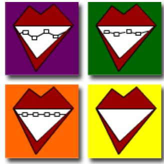

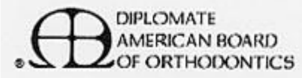

Stephen W. Bradford, D.M.D., P.A.
Practice Limited to Orthodontics and Dentofacial Orthopedics
***Member* AMERICAN ASSOCIATION OF ORTHODONTISTS**

Patient History and Acquaintance Information (Adult)

Please Complete All Blanks

Date: ____________ Family Dentist**:** ___________________________
Referred by: ________________________
Name:____________________ Nick name: ____________________________
Age: _____________ Birth date: __________________Patients Sex: ____
E-mail: _____________________________________**Mobile phone:** ____________________________________
Employer: ____________________________ Business Address: ____
Marital Status: ___Single ___Married ___Divorced ___Separated
Business Phone: _______________________
Name and ages of any children in the family:____

Dental and Medical History

Has an Orthodontist been consulted previously? ____Yes _____No Dr:____________________ Date:________
Have you had orthodontic treatment previously? ____Yes _____No Dr.____________________ Date:________
Date of last dental checkup:________________ Were the teeth cleaned? _______Yes _______No
How many times per day do you **brush** your teeth? ____0 _____1_____2_____3 **floss?**___0___1___2

Check Yes or No for which you have been diagnosed or treated. __If Yes, please specify__.

__Yes __No Anemia
__Yes __No Blood Disease
__Yes __No Hepatitis
__Yes __No Risk Group/AIDS
__Yes __No Jaundice
__Yes __No Rheumatic Fever
__Yes __No Heart Disease
__Yes __No Tuberculosis
__Yes __No Diabetes
__Yes __No Endocrine Problems
__Yes __No Bone Disorders
__Yes __No Epilepsy/Seizures

__Yes __No Herpes
__Yes __No Tonsilitis/Adenitis
__Yes __No Tonsils Removed
__Yes __No Adenoids Removed
__Yes __No Asthma
__Yes __No Mouth breathing
__Yes __No Allergies
__Yes __No Drug Sensitivity
__Yes __No Under Physicians Care
__Yes __No Systemic Medications
__Yes __No Unusual Illnesses
__Yes __No **In Good Health?**

__Yes __No Speech Problems
__Yes __No Head/Face Injuries
__Yes __No Dental Injuries
__Yes __No Thumb/Finger Habit
__Yes __No Difficult Oral Surgery
__Yes __No Clench/Grind Teeth
__Yes __No Missing/Extra Teeth
__Yes __No Clicks/Pops of Jaw Joint
__Yes __No Frequent Head/Ear Aches
__Yes __No Need for Pre-medication
__Yes __No Any Current Medications
__Yes __No **Any Other Concerns?**

__Yes __No Are you taking biophosphonates (a medicine for bone disorders or osteoporosis)?
Specific Notes:____
____
Any Known Allergies: ____

Family Physician:_________________________ Phone:__________________ Date of last visit:________
Would you consider your health to be: _____Excellent _____Good _____Fair ______Poor?

Person(s) to be notified in Case of Emergency: ______________________________**Phone:**___________

I hereby certify that I have reviewed the above health history and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will inform Dr. Bradford and staff of these changes. This information, important for our records and your health is confidential.

Signature of Responsible Party: ____**Date:**____________
Updates: ______/_______/_______/_________

PLEASE FILL OUT ALL KNOWN INFORMATION

Patient Information Page

Patient's name: ___________________________________

Address: ____

Home Phone:_____________________ **Mobile Phone**: ____

Birth date: __________________ Sex: ______

Social Security #: _________________ **E-mail address**_______________________________

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

General Dentist: ___________________________

Family member in or out of orthodontic treatment:_____________________________________

Responsible Party Information

Name:____

Mailing Address: ____

How long at this address: _______ Home Phone:___________________________

Previous Address (if less than 3 years)__________________________________ How long:___________

Patient's Marital Status: _______ Dr. License #: ___________________

Employer: ______________________ Occupation: _________________ # of years employed: ____Work Phone: ___________

Employer Address: ____

Spouse's Name: _______________________________

Employer: ______________________ Occupation: ________________ # of years employed: _____Work Phone:___________

Soc. Sec. #:________________ Dr. License #:________________________________ DOB: _______________

Employer Address: ____

Insurance Information ____

Insured's Name: ____

Insured's Social Security #: _________________________

Insurance Company: Group#: ____________ Local #: _______________

Insurance Company Address: ____ Phone#: _______________

Do you have dual coverage? _____Yes _____No If yes, please complete the information below.

Insured's Name: _____________________________________Insured's Social Security #: __________________

Insurance Company: __________________________ Group#: ____________ Local #: _______________

Insurance Company Address: ____ Phone#: _______________

I, ________________________, give Dr. Bradford's office permission to check my credit history through the Credit Bureau. I understand that by doing so there will be a notation on my record of the inquiry. This inquiry is necessary to obtain financing through Dr. Bradford's office for orthodontic care of the above named patient. ___________________

Signature: ____Date: ____

Previous Orthodontist Information

If transferred, name of previous orthodontist: _________________________ ***Phone:***_____________

Complete Address: ____