ADULT EXAMINATION CARD

Email_____

Date of Examination: _____ Date of Birth: _____

Patient's Name: _____ Age: _____ Sex: _____
(Last) (First) (MI)

Residence Address: _____
(Street) (City) (State) (Zip)

Patient's Phone: _____ Occupation: _____

Social Security #: _____ Employed by: _____

Cell Phone: _____ Work Phone: _____

Patient's Spouse (If Married): _____ Occupation: _____

Social Security #: _____ Employed by: _____

DOB: _____ Cell: _____ Work Phone: _____

Person Financially Responsible: _____ Relationship to Patient: _____

Billing Address: _____
(Street) (City) (State) (Zip)

Nearest Relative & Phone: _____

If you have orthodontic insurance/Name of Insured: _____

Insurance Company: _____ Name of Employer Carrying Insurance: _____

Employee's Name: _____ Social Security #: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Patient's Physician: _____

Have tonsils and adenoids been removed? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Check any of the following for which the patient has been treated:

❑ Diabetes	❑ Tuberculosis	❑ Endocrine Problem	❑ Pneumonia
❑ Anemia	❑ Prolonged Bleeding	❑ Heart Trouble	❑ Epilepsy
❑ Fainting or Dizziness	❑ Rheumatic Fever	❑ Bone Disorder	❑ Kidney Disorder
❑ Asthma	❑ Anxiety Disorder	❑ Liver Disorder	❑ HIV/AIDS
❑ Heart Disease	❑ Lung Disease	❑ Hepatitis	

List any other serious illness and operations not mentioned above: _____

_____

List any allergies or drug sensitivities: _____

DENTAL HISTORY

What is your main concern? _____

Patient's Dentist: _____

Have there been any injuries to the face, mouth or teeth? ❑ Yes ❑ No

Has the patient ever sucked a thumb or finger? ❑ Yes ❑ No

Has the patient had speech therapy? ❑ Yes ❑ No

Please complete "Dental History" on back.

Is the patient a mouthbreather? While Awake? ❑ Yes ❑ No While Asleep? ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

OFFICE USE ONLY

1. Facial Pattern:
2. Habits:
3. Lip Tone:
4. Classification:
5. Crowding:
6. Overbite:
7. Overjet:
8. Additional Observations:
9. Suggestions and Possible Treatment:
10. Fee:
11. Parent Reaction:
12. Patient Reaction:
13. TMJ Findings:
14. Additional Remarks:

CLOUD LITHO - ABILENE, TX