Kulits Orthodontics Date_____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Birthdate_____ Social Security # _____

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

Confidential Responsible Party Information

Name _____ □ Married □ Single □ Separated
Last First Middle

Residence_____ □ Own □ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

How long at this address_____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____Work Phone _____Cell Phone _____

Social Security #_____ Birthdate _____ Relationship to Patient_____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Name _____ Relationship to Patient _____ Birthdate _____
Last First Middle

Employer _____ Occupation_____ # Years Employed _____

Insurance Information

Policy Holder's Name _____ Soc. Sec. # /or ID #_____

Insurance Company _____ Group # _____Union Local # _____

Insurance Co. Address _____Insurance Co. Phone_____

Policy Holder's Employer _____

Do you have dual coverage? No □ Yes □ If yes: _____

Policy Holder's Name _____ Soc. Sec. #/ or ID _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor) _____

Updates (date and initial) _____

Please complete the Medical History on the reverse side

Medical History

Physician's name: _____ Telephone #: _____ Date of last visit: _____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____
Are you taking prescription or over-the-counter drugs? ☐ Yes ☐ No
Please list each medication: _____
For women: Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #: _____ Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Anemia/Radiation Treatment	☐ Yes ☐ No	Heart Surgery/Pacemaker	☐ Yes ☐ No
Artificial Bones/Joints	☐ Yes ☐ No	Hemophilia/Abnormal Bleeding	☐ Yes ☐ No
Artificial Valves	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Asthma/Arthritis	☐ Yes ☐ No	High/Low Blood Pressure	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	HIV+ / AIDS	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Hospitalized for any Reason	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Difficulty Breathing	☐ Yes ☐ No	Mitral Valve Prolapse/Murmur	☐ Yes ☐ No
Drug/Alcohol Abuse	☐ Yes ☐ No	Psychiatric/Scarlet Fever	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Severe/Frequent Headaches	☐ Yes ☐ No
Epilepsy/Seizure	☐ Yes ☐ No	Shingles/Herpes Zoster	☐ Yes ☐ No
Fever Blister/Herpes	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart Attack/Stroke	☐ Yes ☐ No	Ulcers/Colitis	☐ Yes ☐ No
Snoring/Sleep apnea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No

Please list any serious medical conditions you have ever had: _____
Are you allergic to any of the following?

Aspirin	☐ Yes ☐ No	Dental Anesthesia	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No	Metal or Plastic	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Other	☐ Yes ☐ No

Please list any other medications you are allergic to: _____

Dental History

What are you main reasons for seeking orthodontic treatment? _____

_____

Have you ever had orthodontic treatment? ☐ Yes ☐ No If so, when?_____
Have you ever had a serious/difficult problem with previous dental work? ☐ Yes ☐ No
Do you now or have you ever had pain in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Have you ever injured your ☐ Mouth ☐ Teeth ☐ Chin
Do you have any missing or extra permanent teeth? ☐ Yes ☐ No
Do you generally breathe through your mouth when awake? ☐ Yes ☐ No When asleep? ☐ Yes ☐ No
Do your gums ever bleed? ☐ Yes ☐ No Do you have any speech problems? ☐ Yes ☐ No
Do you grind your teeth or clench you jaws? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No
Is your bite comfortable? ☐ Yes ☐ No

Name of your dentist: _____ Date of last visit: _____

The information I have given today is correct to the best of my knowledge. I understand that this information 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