Brian C. Fryar, D.D.S., M.S.D.

LaPorte Orthodontics, Inc

Member **American Association of Orthodontics**

Adult Medical History

Patient's Name _____ Date _____

Physician's Name _____ Date of last physical exam _____

Your birthdate _____ Age _____

Do you have or have you had any of the following. Please indicate with check mark (✓)

_____ Any Heart Problems
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Circulatory Problems
_____ Nervous Problems
_____ Radiation Treatments
_____ Excessive Bleeding
_____ Allergies To Anesthetics
_____ Allergies to Medicines or Drugs

_____ Allergies To
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Diabetes
_____ Hepatitis
_____ Malignancies
_____ Measles
_____ Mumps
_____ Psychiatric Care

_____ Rheumatic Fever
_____ Scarlet Fever
_____ Sinus Problems
_____ Stroke
_____ Typhoid Fever
_____ Tonsilitis
_____ Tuberculosis
_____ Ulcer
_____ HIV Positive / Aids

_____ Are You Pregnant?

Do you have a tendency to colds? _____ Sore throats? _____ Ear infections? _____

Have your tonsils and adenoids been removed? _____ What age? _____

List any allergies: _____

_____

What medications are now being taken? Please give reason: _____

_____

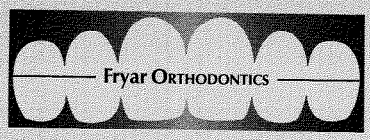
Patient's Dental History

Have there ever been any injuries to the face, mouth or teeth?	yes	no
Have you ever sucked your fingers or thumb? Until what age?	yes	no
Do you have any speech problems?	yes	no
Are you a mouth breather? While awake?	yes	no
While asleep?	yes	no
Have you been informed of any missing or extra permanent teeth?	yes	no
Have you consulted an orthodontist previously?	yes	no
Did either parent have orthodontic treatment?	yes	no

Do you have pain in the jaw points? ❑ Right ❑ Left Do you have popping or cracking of the jaw joint? ❑ Right ❑ Left

When did this begin? _____

Brian Fryar, D.D.S., M.S.D



Member American Association of Orthodontics

Patient Information

Date _____

Patient's Name _____
Last First Nickname Middle

Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Age _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

General Dentist _____

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

Responsible Party Information

❑ Same as above

Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____

Spouse's Name _____
Last First Middle

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Phone # _____ ID # _____

Insurance Co. Address _____

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

Insured's Name _____ Insured's Soc.Sec. # _____

Insurance Company _____ ID # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Relationship to patient _____

Complete Address _____

Phone _____

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

Signature _____