CHOI
ORTHODONTICS

New Patient Information (Adult)

Patient Information

Today's Date _____ Male ☐ Female ☐ Age _____ Birthdate _____/_____/_____
Name _____ Nick Name _____
Address (Street, City, State, Zip) _____
Home phone _____ Cell phone _____
E-mail _____
Height _____ Weight _____
Medical Condition _____
Medication _____ Allergy _____
General dentist _____ Last dental exam _____
Prior orthodontic treatment: Yes ☐ No ☐ If yes, when _____
Previous injury to face, mouth, teeth, or chin: Yes ☐ No ☐ If yes, when _____
What are your concerns about the smile?
Overbite ☐ Under bite (crossbite) ☐ Crowding ☐ Spacing ☐ Other _____
Habit: Thumb sucking ☐ Mouth breathing ☐ Grinding ☐ Clenching ☐ Other _____
Sports: _____ Musical instruments: _____
Occupation _____ Employer _____
Work phone _____
Emergency contact _____ Phone _____ Relationship _____

How did you hear about our office?
Referral ☐ (Name _____) Internet ☐ Sign ☐ Yellow Page ☐

Insurance Information

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Primary

Insurance company name _____ Phone _____
ID # _____

Insured's name _____ Insured's birthdate _____/_____/_____
Relationship _____ Insured's SS # _____
Insured's employer _____

Secondary

Insurance company name _____ Phone _____
ID # _____

Insured's name _____ Insured's birthdate _____/_____/_____
Relationship _____ Insured's SS # _____
Insured's employer _____