

Patient No: _____

1. **ADULT: Personal History**

Date: _____

Name: _____ S.S. # _____

Age: _____ Birth Date: _____ Sex: _____ H: _____ W: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Number: _____

Cell Number: _____ Home Number: _____

Spouse's Name: _____ S.S. # _____

Employer: _____ Work Number: _____

Cell Number: _____ Home Number: _____

Primary Ins.: _____ Secondary Ins.: _____

Referred By: _____ Dentist: _____

Hobbies/Interests: _____

2. **DENTAL HISTORY**

Have there been injuries to: (circle) Face Mouth Teeth Neck

If Yes, explain: _____

Has patient ever sucked thumb/finger? _____ Until what age? _____

Does patient have a speech problem? _____

Is patient a mouth breather? _____

- > I understand that I, not my insurance company, will be responsible for the entire account and for any expense incurred through the collection of this account. My signature below indicates that I assign all insurance benefits to be paid to Dr. Williams. If diagnostic records are taken, there will be a \$295 charge. This is not included in the amount quoted at consultation appointment.
- > If financing treatment, credit bureau reports may be obtained.

Responsible Party Signature: _____

3. **TO BE COMPLETED BY DOCTOR**

Classification: _____

Arch Development: _____

Overbite: _____ % OverJet: _____ mm

Crowded Segments: _____

Diastema: _____

Habits: _____

Recommendations: _____

R								L							
			e	d	c	b	a	a	b	c	d	e			
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			e	d	c	b	a	a	b	c	d	e			