

We are happy you're here!



CLARK BROWNE  
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Orthodontics for Children and Adults  
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**ADULT**

A B C

**Patient Information**

Date \_\_\_\_\_ Age \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Dentist \_\_\_\_\_

Whom may we thank for recommending our services? \_\_\_\_\_

Names and ages of children in family \_\_\_\_\_ Have any been seen in this office? Yes \_\_\_\_\_ No \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number of years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_  
Last First Middle Occupation \_\_\_\_\_ Number of years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Responsible Party E-mail for appointment reminders etc. \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Contract Number \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Contract Number \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Phone \_\_\_\_\_

To the best of my knowledge, the 2 pages of information (front and back) is complete and correct. I give my permission for any photographs, X-rays or study models to be used for displays at scientific presentations and/or publications of a scientific nature or for group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. Also, I understand that where appropriate, credit bureau reports may be obtained.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Patient or Parent or Guardian if Patient is a Minor

# Please Answer All Questions

**A. What are your main concerns regarding the jaws and teeth?**

- Crowding
- Over-bite
- "Buck" teeth
- Receded jaw
- Prominent jaw
- Smile concerns
- Spaces
- Gum disease/recession
- Extra/Missing teeth
- Jaw dysfunction
- Mouth too small
- Clicking jaw joint
- Irregularly shaped teeth
- Protrusion of teeth
- Ringing/Stuffiness of ears
- Headaches/Facial pain
- Neck pain
- Jaw pain
- Irregular facial proportions
- Other \_\_\_\_\_
- No Concerns

**B. Other family members with similar orthodontic condition?**

- Father
- Mother
- Brother
- Sister
- Other \_\_\_\_\_

**C. Medical/Dental History**

1. Present Health    Good    Fair    Poor
- a. Physical
- b. Emotional
2. Have you ever had any of the following conditions?
- Allergies
  - Arthritis
  - Asthma
  - Autoimmune disorder
  - Blood disease
  - High blood pressure
  - Low blood pressure
  - Bone disorders
  - Cancer
  - Diabetes
  - Dizziness
  - Epilepsy

- Endocrine problems
- Emotional problems
- Female problems
- Hepatitis
- Heart disease
- Hearing disorder
- Kidney disease
- Rheumatic fever
- Ringing of ears
- Sleep disturbances
- Received trauma (teeth, face, jaws or head)
- Other \_\_\_\_\_
- None

**D. MEDICATIONS: Current medication**

- Heart pills (digitalis, etc.)
- Antibiotics
- Diet pills (diuretics)
- Pain pills (demerol, codeine, etc.)
- Vitamins
- Birth control pills
- Sleeping pills
- Muscle relaxants
- Insulin
- Other \_\_\_\_\_
- None

**E. ALLERGIES TO MEDICATION/FOOD**

- Have you demonstrated an allergic response to:
- Antibiotics (specific)
  - Pain pills (codeine, etc.)
  - Dairy products
  - Latex, metals, etc.
  - Dyes in food
  - Other \_\_\_\_\_
  - None

**F. The following are also of interest to the orthodontist.**

- Do you:
- 1. Snore when sleeping?    Yes    No
  - 2. Mouth Breather:  
 Seldom  
 Sometimes  
 Usually

- 3. Have difficulty chewing?    Yes    No
- 4. Have pain in the jaw joint?
- 5. Have clicking in jaw joint?
- 6. Have speech problems?

**G. The following habits are of interest to the orthodontist:**

- 1. Clenching/Grinding of teeth?    Yes    No
- 2. Tongue thrusting?
- 3. Smoking?
- 4. Other habits?

**H. How often do you have Dental Check-ups?**

- Twice a year
- Once a year  
Date of last Dental checkup \_\_\_\_\_
- Only if urgent
- Never

**I. Orthodontic consultation prompted by:**

- Patient     Sibling
- Dentist     Physician
- Mother     Friend
- Father     Other \_\_\_\_\_
- Spouse

- J. Have you had previous orthodontic consultation or treatment?    Yes    No

- K. Have you had any unusual dental experiences?    Yes    No

- L. Are there any medical, dental, or surgical problems not covered above?    Yes    No