ROBERT M. WAXLER, D.M.D., M.S.
JEFFREY T. CAVANAUGH, D.D.S.

CENTURY
Orthodontics
Our Third Century of Orthodontic Excellence

Members
American Association of
Orthodontists

(636) 391-0499

410 Sovereign Court, Suite 19 ■ Manchester, MO 63011
8000 Bonhomme, Suite 407 ■ Clayton, MO 63105

ADULT PATIENT INFORMATION

TODAY'S DATE ____/____/____

** Please complete and return by mail if you have the time. If not please bring completed form to the office. It will save you time at the office.*

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. _____

Birth date _____ Age _____ Social Security # _____ E-mail Address _____

Home Address _____

City _____ State _____ Zip _____ Home Phone # _____

Would you object to an automated telephone call to remind you of an upcoming appointment? ❑ Yes ❑ No

Employer _____ Address _____

City _____ State _____ Zip _____ Business Phone # _____

Occupation _____ Insurance _____

❑ Married ❑ Separated ❑ Single

Spouse's name _____ Social Security # _____

Employer _____ Address _____

City _____ State _____ Zip _____ Business Phone # _____

Occupation _____ Dental insurance _____

Person & address responsible for account *(credit bureau reports, where appropriate, may be obtained)* _____

Physician _____ Date of last complete examination _____

Dentist _____ Since _____ Date of last dental examination _____

Other Dentist(s) _____ Specialty(s) _____

Have you completed all recommended dental work? ❑ Yes ❑ No Do you see your dentist on a regular basis? ❑ Yes ❑ No

How did you come to choose our office *(indicate as many as applicable)*

❑ dentist referral ❑ insurance plan referral ❑ location _____

❑ other family members treated at this office: Names _____

❑ recommendations of neighbors and friends: Names _____

❑ other (physician, Yellow Pages, dental society, etc.) _____

Have you recently had an orthodontic evaluation or orthodontic diagnostic records taken? ❑ Yes ❑ No

Have you ever had previous orthodontic treatment or worn a "retainer" or "biteplate"? _____

When? _____ By? (Dentist, Orthodontist) _____

Have you been treated for peridontal (gum) disease? _____

When? _____ By? (Dentist, Periodontist) _____

What is your primary concern (why are you here?) _____

Please complete other side

Please check YES or NO. If Yes, please fill in details.

❑ Yes ❑ No Do you require antibiotic premedication for dental work? _____

❑ Yea ❑ No Do you have a current medical problem? What? _____

❑ Yes ❑ No Do you have heart trouble? Congenital heart lesions? Had rheumatic fever? _____

❑ Yes ❑ No Do you have high or low blood pressure? Is it controlled? _____

❑ Yes ❑ No Have you ever had diabetes? How is it controlled? _____

❑ Yes ❑ No Are you subject to fainting or dizziness? When? _____

❑ Yes ❑ No Do you have epilepsy? Medication? _____

❑ Yes ❑ No Do you have headaches? How often? _____

❑ Yes ❑ No Psychological or nervous disorders? How is it controlled? _____

❑ Yes ❑ No Are you allergic to any medication? Metals? Latex? etc.? _____

❑ Yes ❑ No Endocrine (gland) or blood disorders? kidney disease? anemia? _____

❑ Yes ❑ No Do you have asthma? hay fever? severe allergies? _____

❑ Yes ❑ No Have you ever had infectious hepatitis? jaundice? tuberculosis? _____

❑ Yes ❑ No Have you ever had any major operations? cancer or tumors? _____

❑ Yes ❑ No Radiation treatment to head area? _____

❑ Yes ❑ No Are you taking any medication? Please list: _____

❑ Yes ❑ No Do you use tobacco? How much? _____

❑ Yes ❑ No Have you ever had any sexually transmitted diseases? _____

❑ Yes ❑ No Are you H.I.V. positive? _____

❑ Yes ❑ No Do you perspire excessively at night? Have persistent diarrhea? Have a purplish rash or persistent bruise(s)? _____

❑ Yes ❑ No Have you had prolonged coughing or coughed up blood? _____

❑ Yes ❑ No Have you lost weight recently without dieting? How much? _____

❑ Yes ❑ No Do you have any growth, swellings, or sores in your mouth? _____
How long have they existed? _____

❑ Yes ❑ No Is any part of your mouth sensitive to temperature, pressure, food, or drink? _____

❑ Yes ❑ No Do you ever have any pain or soreness around your eyes, ears, or other parts of your face? _____

❑ Yes ❑ No Bleeding or swollen gums? _____

❑ Yes ❑ No Are you aware of stiff neck muscles? How often? _____

❑ Yes ❑ No Do you ever awaken with awareness of your teeth or jaws? How often? _____

❑ Yes ❑ No Are you aware of clenching your teeth during the daytime? _____

❑ Yes ❑ No Have you ever been told you grind your teeth during sleep? _____

❑ Yes ❑ No Are you aware of your jaw clicking or popping while eating or yawning? _____

❑ Yes ❑ No Do you have difficulty in opening your mouth widely? _____

❑ Yes ❑ No Have your jaws ever locked open or closed? _____

For Women

❑ Yes ❑ No Are you pregnant? Expected delivery date? _____

❑ Yes ❑ No Are you on any hormonal therapy or being treated for potential osteoporosis? _____

Please amplify answers on a separate sheet of paper if necessary.

SIGNATURE _____ DATE _____