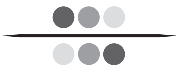

DR. JULIANNE C. PETERSON DDS, MSC **certified specialist in orthodontics**

New Patient Information - Adult

Name: ______________________________ Cell phone number: ______________________________
last first middle

Birthdate: ______________ Age:_____ ○ M ○ F Home phone number: ______________________________
mm/dd/year

E-mail address: ______________________________ Work phone number: ______________________________

Address: ____
number street city province postal code

Occupation: ______________________________

Who will be responsible for this account? ○ Self ○ Other

Responsible party name: Mr / Mrs / Ms / Dr ______________________________

Responsible party address ○ Same as above OR ______________________________
number street city province postal code

Phone: Home: ______________________________ Work: ______________________________

Cell: ______________________________ E-mail address: ______________________________

Do you have any other family members we have treated in our office? ○ Yes ○ No

Names: ______________________________ ______________________________

Were you referred? ○ Yes ○ No Name: ______________________________

Dental History

Dentist: ______________________________ Last dental check-up: ______________________________

How often do you brush your teeth? ______________________________ Do you floss daily? ○ Yes ○ No

Do/did you have a history of the following?

- ○ Clenching/grinding
- ○ Clicking/pain in jaw joint
- ○ Difficulty chewing/swallowing
- ○ Injuries to face/mouth/teeth
- ○ Tonsils/adenoids removed
- ○ Lip sucking/biting
- ○ Mouth breathing
- ○ Nail biting
- ○ Smoking #______ years
- ○ Speech problems
- ○ Tendency to colds, sore throats, ear infections
- ○ Tongue thrust
- ○ Thumb/finger sucking
- ○ Other: ______________________________

Have you ever been treated for a jaw joint problem, including surgery? ○ Yes ○ No

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Have you had previous orthodontic treatment? ○ Yes ○ No

Has anyone else in family had orthodontic treatment? ○ Yes ○ No

What would you like treatment to address? ______________________________

Authorization

To the best of my knowledge, all of the preceding answers are correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in health/medications that are not mentioned above, I will inform the doctor at my next visit.

______________________________ ______________________________
initials date

______________________________ ______________________________
orthodontist's signature date

Medical History

Doctor's name: ______________________ Doctor's phone number: ______________________

Doctor's address: ______________________ Date of last visit: ______________________

Are you currently under the care of a physician? ○ Yes ○ No

Are immunizations current? ○ Yes ○ No

Do you require antibiotics before dental treatment? ○ Yes ○ No

Do you wish to speak to the doctor in private? ○ Yes ○ No

Have you ever taken medications for osteoporosis, bone cancer or bone disease? ○ Yes ○ No

Are you taking birth control pills? ○ Yes ○ No

Are you currently pregnant? ○ Yes ○ No

How is your current physical health? ○ Good ○ Fair ○ Poor

Please list all allergies and sensitivities (especially latex/metals): ______________________

Please list current medications and reason for taking: ______________________

Have you ever taken a Bisphosphonate?______________________

Do you have or experience any of the following?

○ Arthritis
○ Asthma
○ Bleeding disorder
○ Blood pressure - high or low
○ Cancer
○ Diabetes
○ Drug or alcohol abuse
○ Emotional problems
○ Endocrine problems
○ Epilepsy
○ Heart disease
○ Heart murmur
○ Hepatitis
○ HIV/AIDS
○ Hearing impairment
○ Kidney problems
○ Osteoporosis
○ Prosthetic/artificial joints
○ Radiation treatment
○ Rheumatic fever
○ Severe/frequent headaches
○ Shingles
○ Sinus problems
○ Tuberculosis
○ Ulcers/Colitis
○ Other:______________________

Privacy information

We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

I agree that Dr. J. Peterson and/or members or her staff permission to release information concerning my dental/orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

Signature: ______________________ Date: ______________________

Review Dates

______________ ______________
______________ ______________
______________ ______________
______________ ______________
______________ ______________

Doctor's Notes

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