

# ADULT HISTORY FORM

Orthodontics for Adults and Children

Date \_\_\_\_\_

## Confidential Patient Information

A B C

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

Address \_\_\_\_\_  
Street City State zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring ou to our office? \_\_\_\_\_

## Confidential Responsible Party Information

Name \_\_\_\_\_ Martial Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State zip

Mailing Address \_\_\_\_\_  
Street City State zip

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

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State zip

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthday \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information

Policy Holder's Name \_\_\_\_\_ and Soc.Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union, Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Do you have dual coverage? No  Yes  If yes:

Policy Holder's Name \_\_\_\_\_ and Soc.Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

## Emergency Information

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

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Thank you for filling out both sides of this form.

Wheaton Orthodontics Center  
David J. Allen, D.D.S., M.S.