OASIS ORTHODONTICS
Dr. Khushee Sharma, Specialist Orthodontist
B.Sc., D.D.S., M.Sc., M.Orth

PATIENT INFORMATION FORM - ADULT

Date_____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell Phone_____ Birthdate_____ Email Address_____

Whom may we thank for referring you to our office? _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Phone _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Are you aware that some appointments will be during work hours? _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insurance

Company_____ Group No._____ Cert. No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____

Insurance Company_____ Group No._____ Cert. No. _____

Insurance Co. Address_____ Phone No. _____

To the best of my knowledge, the above information is correct:

Patient/Parent Signature: **Date:**

Orthodontist Signature: **Date:**