



Dr. Becky Maher  
Healthy Smiles For A Lifetime!

### Patient Information Adult

Name \_\_\_\_\_ M / F Birthdate \_\_\_\_\_  
Last First MI  
Address \_\_\_\_\_  
Street City St. Zip  
Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_ Cell \_\_\_\_\_  
# of Yrs. @ this address \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_  
General Dentist \_\_\_\_\_ Last Dental Visit \_\_\_\_\_ Other Family Treated Here \_\_\_\_\_  
Who may we thank for referring you to our office \_\_\_\_\_  
Hobbies \_\_\_\_\_

### Spouse/Additional Contact Information

Name \_\_\_\_\_ M / F Birthdate \_\_\_\_\_  
Last First MI  
Address \_\_\_\_\_  
Street City St. Zip  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Email \_\_\_\_\_

### Insurance Information

Primary Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone# \_\_\_\_\_ #Yrs. Employed \_\_\_\_\_  
ID#/SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone# \_\_\_\_\_ #Yrs. Employed \_\_\_\_\_  
ID#/SS# \_\_\_\_\_ Group # \_\_\_\_\_

# Medical History

Physician \_\_\_\_\_ Last Visit \_\_\_\_\_ Phone # \_\_\_\_\_

Are you currently under the care of your physician?  Yes  No If Yes, explain \_\_\_\_\_

Are you pregnant?  Yes  No If so, how many weeks \_\_\_\_\_

Have your Tonsils or Adenoids been removed  Yes  No

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)?  Yes  No

Do you have any missing or extra permanent teeth?  Yes  No

Have you ever had an injury to: (select all that apply)  Teeth  Mouth  Chin

Did you ever have any of the following habits?  Lip sucking/biting  Nail biting  Mouth breather

Prolonged bottle/pacifier  Clenching/Grinding teeth  Tongue thrusting  Thumb/finger Sucking

Do you have speech problems?  Yes  No If yes, explain \_\_\_\_\_

Do your gums bleed?  Yes  No Do you smoke?  Yes  No Do you like your smile?  Yes  No

Have you ever been evaluated for orthodontic treatment? \_\_\_\_\_

What are the main concerns that you would like to accomplish? \_\_\_\_\_

Are you allergic to any of the following?  Aspirin  Codeine  Erythromycin  Latex  Penicillin

Tetracycline  Any metals/plastics

List any other allergies or sensitivities \_\_\_\_\_

List all medications you are currently taking:

List any serious medical conditions treated for:


## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical or dental status.

I hereby authorize the release of any information for the purpose of insurance processing and dental diagnosing by the doctor.

I understand that where appropriate, credit bureau reports may be obtained.

Signature \_\_\_\_\_ Date \_\_\_\_\_