smile@schofieldortho.com
Office: (972) 258-0758
Cell/Text: (469) 900-5371
IrvingOrthodontics.com

SCHOFIELD ORTHODONTICS

2641 Texas Drive
Irving, TX 75062

755 Hwy 121 Byp, A200
Lewisville, TX 75067

Adult Intake and Medical History Form

Please answer completely and to the best of your knowledge. This information is protected under HIPAA regulations.

Patient full name:_____ Preferred name:_____

Gender: _____ Birthday:_____ Age:_____ Ht:_____ Wt:_____

Address: _____Zip:_____

Cell: _____ Alt. phone: _____ Email:_____

Other contact information: _____

Preferred method of non-emergency contact (please check): ☐ Email ☐ Text ☐ Cell ☐ Other

Ethnic heritage: _____ Occupation: _____

Employer name:_____

Responsible party (if different): _____ Relationship: _____

Address (if different): _____

Cell: _____ Alt. phone: _____ Email:_____

Dental insurance company:_____ Group number:_____

Insured name:_____ Social Security number:_____

Group name and group contact phone number:_____

Emergency contact (non-responsible party):_____

Cell:_____ Alt. phone:_____ Email:_____

General dentist:_____ Phone:_____

Date of last dental exam:_____ History of cavities, extractions or toothache (please check): ☐ Y or N ☐

Physician:_____ Phone:_____

List current relevant medical conditions:_____

List medications currently taking:_____

ER, hospital or urgent care visits in the last three years:_____

List surgeries: _____

List allergies (medicine, foods, metals, general):_____

Any past relevant medical conditions:_____

_____

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Main orthodontic concern:_____

_____

_____

Have you had a previous orthodontic consultation or treatment? ☐ Y or N ☐

With whom?_____ When?_____

Did you have a panoramic radiograph (x-ray) taken recently (last 6 months)? ☐ Y or N or I don't know ☐

How did you hear about our office?_____

Has anyone in the family had orthodontic treatment? Who?_____

Any history of the following (Y or N):

Night guard use:	☐ Y or N ☐	Broken fillings or teeth:	☐ Y or N ☐
Food stuck between teeth:	☐ Y or N ☐	Teeth cause irritation to gums/cheek	☐ Y or N ☐
Thumb or finger sucking after five-years-old:	☐ Y or N ☐	Pacifier use after five-years-old:	☐ Y or N ☐
Pain or discomfort in jaws or joint:	☐ Y or N ☐	Dental anxiety:	☐ Y or N ☐
Self-consciousness about teeth:	☐ Y or N ☐	Snoring:	☐ Y or N ☐
Poor breathing through nose:	☐ Y or N ☐	Speech therapy:	☐ Y or N ☐
Excessive sleepiness or tiredness:	☐ Y or N ☐	Cheek or nail biting:	☐ Y or N ☐
Tongue thrust:	☐ Y or N ☐	Depression, anxiety or bipolar:	☐ Y or N ☐
Anorexia or bulimia:	☐ Y or N ☐	Tobacco or marijuana use:	☐ Y or N ☐

Are there any other dental, medical or social issues that have not been address and should be identifie ☐ Y or N ☐

Describe:_____

_____

_____

_____

_____

I have completed this form to the best of my knowledge and not withheld any dental or medical history. Should there be a change or development in the dental or medical history I will make Dr. Schofield aware as soon as possible.

Signature:_____ Date:_____