ZWANZIGER & BOE
ORTHODONTICS

Please Help Us Keep Your Information Updated!

PATIENT INFORMATION FOR ADULT PATIENTS (OVER 18 YEARS OF AGE)

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Employer _____ Occupation _____

General Dentist _____ **Date of last visit** _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____

Group No _____ Local No _____

Insurance Co. Address _____ Phone No _____

Do you have dual dental coverage? Yes_____ No_____ If yes, please complete the following:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____

Group No _____ Local No _____

Insurance Co. Address _____ Phone No _____

Patient Signature _____ Date _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? If yes, please list: _____
_____

Yes No Are you allergic to any medication? If yes, please list: _____
_____

Yes No Do you smoke? _____

Yes No History of a major illness? _____

Yes No Have you had any operations? _____

Yes No Ever been involved in a serious accident? _____

Yes No Have you seen a physician in the last 12 months? Why? _____

For Female Patients Only:

Yes No Are your pregnant? _____

Circle any of the medical conditions below that you currently have or have had in the past:

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? _____
_____

Patient Signature _____ Date _____