Katherine J. Curry, D.M.D.
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ORTHODONTICS &
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LET'S GET ACQUAINTED

ADULT

Today's Date_____ M_____F_____

Dr.☐ Mr.☐ Mrs.☐ Ms.☐

Patient Name_____Birthdate____/____/____Age_____
Last First Middle Initial

Patient Address_____
Street Address City State Zip

Home Phone#(_____)_____ E-Mail Address_____

Patient Employer_____Work #(____)_____ Cell #(____)_____SS #____-_____-_____

Spouse's Name_____ Birthdate_____/_____/_____SS #_____-_____-_____

Spouse's Employer_____Work #(____)_____ Cell #(____)_____

Referred By_____

Name(s) of any other family member previously treated in our office_____

DENTAL HISTORY

Current Family Dentist_____Phone #(_____)_____

Check (✓) if you have had problems with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Food Collection between teeth	☐	☐	Periodontal treatment	☐	☐	Sensitivity to sweets
☐	☐	Bleeding gums	☐	☐	Grinding Teeth	☐	☐	Sensitivity to cold	☐	☐	Sensitivity when biting
☐	☐	Clicking or popping jaw	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity to hot	☐	☐	Sores/growth in mouth

How often do you floss?_____ How often do you brush?_____

HEALTH HISTORY

Physician's Name_____Date of last visit_____
Have you had any serious illness or operations?_____If yes, describe_____
Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____
Women: Are you pregnant or nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No
Has a physician ever told you to premedicate before any dental treatment? ☐ Yes ☐ No
If yes, please explain_____

Check (✓) if you have or have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Aids/HIV positive	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Skin Rash
☐	☐	Tuberculosis	☐	☐	Epilepsy	☐	☐	Jaw Pain	☐	☐	Stroke
☐	☐	Arthritis, Rheumatism	☐	☐	Fainting	☐	☐	High Blood Pressure	☐	☐	Glaucoma
☐	☐	Artificial Heart Valves	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Heart Problem
☐	☐	Artificial Joints/Replacements	☐	☐	Pace Maker	☐	☐	Rheumatic Fever	☐	☐	Scarlet Fever
☐	☐	Back Problems	☐	☐	Chemical Dependency	☐	☐	Circulatory Problems	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Radiation therapy	☐	☐	Cancer	☐	☐	Hemophilia
☐	☐	Blood Disease	☐	☐	Nervous Problems	☐	☐	Respiratory Disease	☐	☐	Asthma
☐	☐	Kidney Problems	☐	☐	Shortness of Breath	☐	☐	Thyroid Problems	☐	☐	Headaches
☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐	Liver Disease	☐	☐	Anemia
☐	☐	Tobacco Habit									

MEDICATIONS

List medications you are taking:

1. _____
2. _____
3. _____

ALLERGIES

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Sulfa
☐	☐	Acetaminophen/Tylenol	☐	☐	Latex
☐	☐	Ibuprofen/Advil	☐		_____

PLEASE COMPLETE BOTH SIDES

PRIMARY DENTAL INSURANCE

Subscriber Name_____
Last First Initial

Relationship to Patient_____Birthdate_____/_____/_____ID #_____

Employer Name_____Occupation_____

Insurance Company_____

Insurance Address_____Phone #_____

Group #_____Orthodontic Benefits: ☐ Yes ☐ No

Notes:_____
Are you covered by additional orthodontic insurance? ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Subscriber Name_____
Last First Initial

Relationship to Patient_____Birthdate_____/_____/_____ID #_____

Employer Name_____Occupation_____

Insurance Company_____

Insurance Address_____Phone #_____

Group #_____Orthodontic Benefits: ☐ Yes ☐ No

Notes:_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I hereby authorize payment directly to: Katherine J. Curry, D.M.D and/or Jimin Oh, D.M.D. of the group insurance benefits otherwise payable to me.

Date_____Signature_____

Date_____Reviewed by_____
Katherine J. Curry, D.M.D. and/or Jimin Oh, D.M.D.

FOR OFFICE USE ONLY

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1. Class I_____ II_____ III_____
2. Mandibular arch length shortage:_____
3. Maxillary anterior teeth: Spaced_____
   Protrusive_____Deep overbite_____
4. Lip Posture Fullness:_____
5. Crossbite: Right_____ Left_____ Anterior_____
6. Finger sucking habit:_____ Tongue thrust:_____
7. Observation: 3mos._____ 6mos._____
8. TMJ: WNL_____ or Describe_____
9. Oral Cancer Screening: No Visible Lesions_____
   Suspected Lesion Location_____
10. Soft Tissue Exam: WNL_____
11. Rx: Full____ Minor____ Invisalign____
12. Doctor: KJC_____ JO_____

PAN:_____ CEPH:_____PHOTOS_____