Adamian ORTHODONTICS
MELINA ADAMIAN DDS, MS

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Please completely fill in the information requested on both sides of this form. A signature is required.

Date _____

Patient Information

Patient's Name _____ Male ☐ Female ☐
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Birth Date _____

Patient's Email Address _____

If patient is a minor, give parent's or guardian's name _____

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

Responsible Party Information

Name _____ Email _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____

Dental Insurance Information

Insured Name #1 _____
ID # of insured _____
Birth Date of Insured _____
Employer _____
Insurance Company _____
Insurance Phone # _____
Insurance Address _____
_____
Insurance Group # _____

Insured Name #2 _____
ID # of insured _____
Birth Date of Insured _____
Employer _____
Insurance Company _____
Insurance Phone # _____
Insurance Address _____
_____
Insurance Group # _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I hereby authorize release of any information to other health care providers, insurance companies and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Melina Adamian, DDS, MS of the insurance benefits otherwise payable to me. I authorize Dr. Adamian to perform a complete orthodontic evaluation.

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or emissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice. I certify that the information on this form is complete and true to the best of my knowledge.

Signature (parent's signature if minor) _____

Member American Association of Orthodontists

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Patient's Medical History

Patient's Physician _____ Phone _____ City _____

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever had your tonsils or adenoids removed? _____

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

[1] Abnormal bleeding/ Hemophilia
[2] Allergies/ Sinus
[3] Anemia
[4] Arthritis
[5] Asthma
[6] Bone disorders
[7] Congenital Heart Defect
[8] Diabetes
[9] Dizziness
[10] Epilepsy/ Seizures
[11] Frequent colds
[12] Gastrointestinal Disorders
[13] Heart murmur
[14] Heart problems
[15] Hepatitis/ Liver problems
[16] Herpes
[17] High blood pressure
[18] HIV/ AIDS
[19] Hyperactivity
[20] Immune Deficiency
[21] Kidney problems/ dialysis
[22] Nervous disorder
[23] Pneumonia
[24] Radiation or Chemotherapy
[25] Rheumatic Fever
[26] Thyroid or Hormonal imbalance
[27] Tuberculosis
[28] Tumor or Cancer
[29] Ulcers
[30] Venereal Disease

Are there any other medical conditions we should be aware of? _____
Are you allergic to Latex? _____ Are you allergic to metal/nickels/jewelry?_____

Do you have a speech problem? If so, are you receiving speech therapy? _____
Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? Yes__No__

Patient's Dental History

Dentist _____ Phone _____ City _____

Date of last cleaning _____

What is your primary concern? _____

Circle Yes or No (If yes, please fill in details)

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Do you have any type of tongue or thumb habit? _____
Yes No Have there been any injuries to your face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to pressure? _____
Yes No Do your gums bleed when you brush or floss? _____
Yes No Do you grind your teeth at night? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever had: (circle all that apply)
Clicking Popping Stiffness Soreness in the jaw or jaw muscles?
Yes No Episodes when the jaw would not open or close normally? _____
Yes No Pain or discomfort in the front of the ear? _____
Yes No Headaches, neck, and/or back pain? _____
Yes No Have you ever seen an orthodontist? _____

To predict patient's growth pattern:
If the patient is under 16, height of: Mom _____ Dad _____
Female Patients: Are you pregnant? Yes No Has menstruation started? Yes No