**Darron R. Mortenson, DMD, MS**

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*Adult form*

Referred By_____ Date _____
Patient's Name_____ Preferred Name _____
Birthdate: _____ Age_____ Sex_____ Married _____Single _____Other _____
Dentist _____ Physician _____
Patient SSN_____ Relationship to Insured_____
Home Address_____
City/State/Zip _____
Hm Phone _____Wk Phone _____Cell_____ Email _____
Occupation _____ Employed By _____
Primary Dental Insurance _____
Insurance Subscriber _____
SSN: _____Date of Birth:_____
Occupation _____ Employed By _____
Name of any family members we have seen _____
Names and ages of other children in the family _____
Person(s) responsible for payment of account, if applicable _____
Address and relationship to patient _____
_____

## MEDICAL HISTORY

Do you consider yourself in good health? Y / N If not, why? _____
Do you have any history of major illness? (Please list with dates) _____
_____
_____
_____

### CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HEART TROUBLE | ☐ | HIV/AIDS | ☐ | ATTENTION DEFICIT | ☐ | LIVER INVOLVMENT | ☐ |
| MITRAL VALVE PRO | ☐ | ANEMIA | ☐ | KIDNEY PROBLEMS | ☐ | HEPATITIS | ☐ |
| HEART MURMUR | ☐ | EPILEPSY | ☐ | ENDOCRINE PROBLEMS | ☐ | BLOOD DISORDERS | ☐ |
| RHEUMATIC FEVER | ☐ | ASTHMA | ☐ | PROLONGED BLEEDING | ☐ | DIABETES | ☐ |
| PNEUMONIA | ☐ | FAINTING OR DIZZINESS | ☐ | TUBERCULOSIS | ☐ | OTHER _____ | ☐ |

Do you have a tendency to: Colds _____ Sore Throats _____ Ear Infections _____ Cold Sores _____
List any drugs or medications now being taken and reason: _____
_____
LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

## DENTAL HISTORY

Date of last dental cleaning _____ Date of last dental X-rays_____
Have there been injuries to the face, mouth or teeth? **Y / N** If yes, describe and give date _____
Do you have any speech problems? **Y / N** Have you ever been told you have periodontal disease? **Y/N**
Any pain in or near the ears? **Y / N**
Have you been informed of any missing or extra permanent teeth? **Y/ N**
Has an orthodontist been consulted previously? **Y / N**
Have you ever had orthodontic treatment before? **Y / N** If yes when? _____
Interests or hobbies _____

*This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may at the discretion of this office; use the services of one or more credit reporting services.*

Signature_____ Reviewed By:_____