



Enriching Lives and Smiles

James C. Lyles, DDS, Inc.
Orthodontics - Facial Orthopedics

Welcome

Patient Information - Adult

Date ___/___/___

Your Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3yrs) _____ Marital Status _____

Birthdate ___/___/___ Social Security # ___/___/___ Alternative Phone _____

Preferred contact numbers: No.1 Hm Wk Alt No. 2 Hm Wk Alt No. 3 Hm Wk Alt

E-Mail Address _____ Please circle one of each preference

Employer _____ Occupation _____ No. Yrs Employed _____

Whom may we thank for referring you to our office?

Spouse Information

Spouse's Name _____ Soc. Sec. # ___/___/___ Birthdate ___/___/___

Work Phone _____ Alternative Phone _____

Employer _____ Occupation _____ No. Yrs Employed _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # ___/___/___

Insurance Company _____ Group # _____ Ph # _____

Insurance Co. Address _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____ Ph # _____

Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Responsible Party Signature _____

CONFIDENTIAL (for record and pretreatment evaluation)

What are your main concerns? What would you would like orthodontics to accomplish?

General Dentist: _____ Date of last visit ____/____

Have you ever been evaluated for or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever experienced any pain / tenderness in your jaw joint (TMJ / TMD)? Yes No

Do you have any speech problems? Yes No

Do you generally breathe through your mouth? Yes No

Your Physician _____ Phone _____

Are you currently under the care of a physician? Yes No

Please describe your current physical health Good Fair Poor

Please list any prescription or over the counter drugs being taken _____

Please list all drugs/things to which you are **allergic** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? (PLEASE CIRCLE)

- | | | |
|--------------------------|------------------------|-------------------------|
| Abnormal Bleeding | Diabetes | Rheumatic/Scarlet Fever |
| Allergies to any Drugs | Handicaps/Disabilities | Tuberculosis |
| Allergic to Latex/Metals | Hearing Impairment | None |
| Allergic to Plastic | Heart Murmur | Other _____ |
| Asthma | Hemophilia | _____ |
| Cancer | Hepatitis | _____ |
| Congenital Heart Defect | HIV+ / AIDS | |
| Convulsions/Epilepsy | Kidney/Liver Problems | |

Please discuss any serious medical conditions that you have ever had _____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. X _____