ADULT
WELCOME TO DR. FLEER'S OFFICE

Date:______________________

NAME:____ HOME PHONE_______________________

CELL PHONE:_____________________________E-MAIL____

PATIENT'S DENTIST____DATE OF LAST DENTAL EXAM_______________________

BIRTHDATE__________ REASON FOR CONSULTATION:____

ANY PREVIOUS ORTHODONTIC TREATMENT:____

WHOM DO WE THANK FOR REFERRING YOU TO THIS OFFICE?____

GENERAL HEALTH:

DOCTOR:____DATE OF LAST PHYSICAL EXAM___________________

ANY HISTORY OF (UNDERLINE THE CONDITION)

HEART TROUBLE **ALLERGIES** **DIABETES** **ASTHMA**

KIDNEY OR LIVER INVOLVEMENT **EPILEPSY** **BLEEDING DISORDERS** **RHEUMATIC FEVER**

NOTE CURRENT MEDICATIONS:____

PATIENT'S HEALTH: **EXCELLENT** **GOOD** **FAIR** **POOR**

ORAL HABITS: **FINGER SUCKING** **NAIL BITING** **MOUTH BREATHING**

LIP OR TONGUE BITING **SPEECH PROBLEMS** **TONGUE THRUSTING**

FAMILY INFORMATION:

PATIENT'S ADDRESS:____

OCCUPATION____WORK PHONE #___________________________

SS # OF PATIENT____

WHAT IS THE PREFERRED TELEPHONE NUMBER ____ HOME ____WORK ____CELL

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES ON YOUR CELL PHONE? ______YES ______NO

SIGNATURE____DATE_____________