KNECHT
ORTHODONTICS

9115 Eagle Dr, Suite 300
Houston, TX 77534

(832) 982-1281

PATIENT INFORMATION *for* ADULT

Date: ____________________

Full Name: ____ Nickname: _________________ Gender: __________

Date of Birth: _____________________ Age: _____ SSN: _________________________ Marital Status: ___________

Address: ________________________________ City: _____________________ State: _________ Zip: _____________

Cell #: _________________________ Home #: ________________________ Email: ______________________________

Has anyone in your family been treated in our office? ____

Please CIRCLE how you would you like to receive appointment reminders: Email Text Message Both

Your Employer

Employer: ___________________________________

Occupation: _________________________________

Business phone: ______________________________

Your Spouse

Spouse's Name: ______________________________

Spouse's Employer: ___________________________

Cell #: _____________________________________

Date of Birth: ________________________________

Social Security #:

Responsible Party Name: ____________________________

How did you hear about our office? Dentist Website Facebook Instagram Friend: ____________________

Are you on Facebook? Yes No Please join us @ www.facebook.com/knechtorthodontics

Are you on Instagram? Yes No Please join us @ knechtorthodontics

MEDICAL HISTORY

Please Circle All Conditions That Apply:

Heart abnormality	Diabetes	Cancer/Tumor	Hearing Impairment
Rheumatic/Scarlet fever	HIV/AIDS	GI Disorder	Speech Disorder
Artificial Heart Valve	Hepatitis	Epilepsy/Seizures	Fainting/Dizziness
High/Low Blood Pressure	Bronchitis	Autism	Nervous/Anxious
Kidney/Liver problems	Asthma	Cleft Lip/Palate	Tactile Defensive

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the practice of any medical or dental changes to this record.

DENTAL HISTORY

Have you previously had any:

Y N Abscessed permanent teeth

Y N Injured/chipped teeth

Y N Periodontal disease/treatment

Y N TMJ problems (clicking/pain)

Y N Major injuries to jaw/face

Y N Jaw/orthognathic surgery

If yes, please explain:

Do you currently have any:

Y N Missing permanent teeth

Y N Dental implants

Y N Active dental decay/cavities

Y N TMJ problems (clicking/pain)

Y N Clenching/grinding habits

Y N Retainers (fixed or removable)

Patient's Dentist: Last Dental Visit:

Do you currently have any planned dental treatment? Yes No Please explain:

Any previous orthodontic treatment? Yes No If yes, at what age:

Any recent orthodontic consultations? Yes No If yes, how long ago:

What treatment was recently recommended?

What would you like orthodontics to accomplish?

Patient's Signature: ________________ **Date:** __________