WAGNER, KUNTZ & GRABOUSKI, PC

Adult Exam Card

Date_____ ID# (office) _____

Name of Patient	Birthdate	M/F	Social Security #
Address	City	State	Zip
E-Mail Address	Work Phone	Home Phone	
Employer			
Employer Address	City	State	Zip
Name of Spouse	Birthdate		
Employer	Social Security #		
Employer Address	Work Phone		

Orthodontic Insurance Information

Insurance Company Name:	Secondary Insurance Company Name
Name of Insured	Name of Insured
Insurance Company Address	Insurance Company Address
City – State – Zip	City – State – Zip
Policy #	Policy #
Title 19 # (If covered by Title 19 give card to receptionist)	
Name of General Dentist	
Has any other member of the family been treated in this office? If so, who?	
Who may we thank for referring you?	
Has patient been seen by another orthodontist?	

Does the patient have a history of any of the following? (Check yes or no)

Rheumatic Fever or Heart Disease	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Tonsil or Adenoid Problems	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Is Patient Taking Any Medications	❑ Yes	❑ No	Blood Disorders	❑ Yes	❑ No
Popping, Clicking, or Pain with Lower Jaw Movement	❑ Yes	❑ No	Allergies	❑ Yes	❑ No

Does any other condition exist other than those mentioned above?

Reason for seeking orthodontic treatment

Date	
Diagnosis:	❑ Class I ❑ Class II ❑ Class III
Treatment Plan:	
❑ Non-Extraction ❑ Extraction Estimated For _____ _____	❑ One Arch ❑ Both Arches ❑ Clear Braces