Health / Dental History for Adult

PATIENT INFORMATION

Patient's Name:________________________________ Preferred Name:____________________

Sex: ☐ Male ☐ Female Age:______ Birthdate:_____/_____/_____ SS#__________________

Home Address:____

City:________________________________ State:__________ Zip:_______________

Cell Phone:___________________________ Home Phone:_____________________________

Work Phone:___________________________ Email:__________________________________

Employer:_________________________ Occupation:___________________ Years There:_____

Who recommended an orthodontic evaluation:____

How did you hear about our office:____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SPOUSE INFORMATION

Spouse Name:________________________________ Birthdate:_____/_____/_____

SS#:_____________________________ Cell Phone:_____________________________

Work Phone:__________________________ Employer:_________________________________

Occupation:___________________ Years There:_____

FAMILY INFORMATION

Child's Name:_______________________________________ Birthdate:_____/_____/_____

Child's Name:_______________________________________ Birthdate:_____/_____/_____

Child's Name:_______________________________________ Birthdate:_____/_____/_____

Child's Name:_______________________________________ Birthdate:_____/_____/_____

RESPONSIBLE PARTY INFORMATION

☐ Self ☐ Spouse ☐ Other

Name:_______________________________________ Relationship to Patient:________________

Birthdate:_____/_____/_____ SS#:_____________________________

Address:____

City:____________________ State:____ Zip:________ Phone:_________________________

INSURANCE INFORMATION

Insurance Company:________________________________ Phone:________________________

Insured Name:_______________________ Birthdate:_____/_____/_____ SS#_______________

ID#:_____________________ Group #:_______________ Employer:______________________

Secondary Insurance Company:________________________ Phone:_______________________

Insured Name:_______________________ Birthdate:_____/_____/_____ SS#_______________

ID#:_____________________ Group #:_______________ Employer:______________________

EMERGENCY CONTACT INFORMATION

Name:____________________________________ Relationship to Patient:__________________

City:_____________ State:_____ Phone:___________________ 2nd Phone:________________

DENTAL INFORMATION

Dentist:____________________ Phone:________________ Date of Last Visit:________________

Dental History

- ☐ Y ☐ N Pre-Medicate for Dental Treatment
- ☐ Y ☐ N Trauma to Teeth
- ☐ Y ☐ N Trauma to Face/Jaw/Chin
- ☐ Y ☐ N Missing Permanent Teeth
- ☐ Y ☐ N Extra Permanent Teeth
- ☐ Y ☐ N Gum/Periodontal Disease
- ☐ Y ☐ N Gum/Periodontal Treatment
- ☐ Y ☐ N Bad Bite
- ☐ Y ☐ N Jaw Pain
- ☐ Y ☐ N Jaw Popping/Locking
- ☐ Y ☐ N TMJ Treatment
- ☐ Y ☐ N Ringing in Ears
- ☐ Y ☐ N Frequent Cold Sores
- ☐ Y ☐ N Dental Implants

Habits

- ☐ Y ☐ N Grinding/Clenching
- ☐ Y ☐ N Lip/Cheek Biting
- ☐ Y ☐ N Nail Biting
- ☐ Y ☐ N Snoring/Mouth Breathing

Orthodontic History

- ☐ Y ☐ N Previous Orthodontic Evaluation
- ☐ Y ☐ N Previous Orthodontic Treatment

What are the main concerns that you would like orthodontic treatment to accomplish?

____

____

Mostly Concerned with: ☐ Appearance ☐ Quality ☐ Cost ☐ Comfort ☐ Time

MEDICAL INFORMATION

Physicians Name:____________________________ Phone:____________________

Medical History

- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Artificial Bones/Joints/Valves
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Blood Disorders
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Convulsions/Epilepsy
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Drug Addition
- ☐ Y ☐ N Endocrine/Thyroid Problems
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Handicaps/Disabilities
- ☐ Y ☐ N Headaches/Earaches
- ☐ Y ☐ N Hearing Problems
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Defects
- ☐ Y ☐ N Heart Surgery
- ☐ Y ☐ N Hepatitis (Type_________)
- ☐ Y ☐ N High/Low Blood Pressure
- ☐ Y ☐ N HIV Positive or AIDS
- ☐ Y ☐ N Kidney/Liver Problems
- ☐ Y ☐ N Psychiatric Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Serious Illness
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Surgery
- ☐ Y ☐ N Tobacco Use
- ☐ Y ☐ N Tonsils/Adenoids Removed
- ☐ Y ☐ N Tuberculosis

Allergies

- ☐ Y ☐ N Latex
- ☐ Y ☐ N Nickel/Metals
- ☐ Y ☐ N Plastic

Drug/Additional Allergies:____________________

Current Medications:____________________

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Women Only:
☐ Pregnant ☐ Nursing ☐ Taking Birth Control

I, understand and have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problem arising out of inadequate information not disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that, where appropriate, a Credit Bureau Report may be obtained.

____________________ ____________ ________________

(Patient Signature) (Date) (Orthodontist)