Adult Health History Form

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1. About You

Today's Date: _____ ☐ Male ☐ Female

Name: _____
LAST FIRST MI

Preferred Name: _____

Birthdate: __/__/____ Age: _____

Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Widowed ☐ Married
☐ Divorced ☐ Separated

Home #: (___) _____ Cell #: (___) _____

Work#: (___) _____ Ext.: _____

Email: _____

Employer: _____

Occupation: _____ How Long? _____

Where & when are the best times to reach you?

_____

_____

Whom may we thank for referring you? _____

_____

Other family members seen by us: _____

_____

General Dentist: _____

Last Visit Date: _____

2. Spouse Information

Name: _____

Employer: _____

Cell #: (___) _____ SS #: _____

Birthdate: __/__/____

3. Orthodontic Insurance

Primary Orthodontic Coverage

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/____ SS #: _____

Policy Owner's Employer: _____

Secondary Orthodontic Coverage

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/____ SS #: _____

Policy Owner's Employer: _____

4. Medical History

Do you have a personal Physician? ☐ Yes ☐ No

Physician Name: _____

Phone #: (___) _____ Date of last vist: _____

Are you currently under the care of a physician for any type of illness? ☐ Yes ☐ No

Please explain: _____

Your current dental health is:
☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the counter drugs? ☐ Yes ☐ No

List all: _____

4. Medical History (continued)

For Women: Are you taking birth control pills?

☐ Yes ☐ No

Are you pregnant?

Week #: _____ ☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

Have you ever had any of the following diseases or medical conditions?

Y N Abnormal Bleeding
Y N Heart Surgery/Pacemaker
Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints/Values
Y N High/Low Blood Pressure
Y N Hospitalized for Any Reason
Y N Severe/Frequent Headaches
Y N Diabetes/Tuberculosis (TB)
Y N Rheumatic/Scarlet Fever
Y N Epilepsy/Seizures/Fainting
Y N Difficulty Breathing
Y N Emphysema/Glaucoma
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Hemophilia
Y N Asthma/Arthritis
Y N Hepatitis
Y N Blood Transfusion
Y N HIV+/AIDS
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Drug/Alcohol Abuse
Y N Shingles
Y N Sinus Problem
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N Aspirin Y N Penicillin Y N Dental Anesthetics
Y N Latex Y N Tetracycline Y N Any Metals/Plastics
Y N Codeine Y N Erythromycin Y N Other

Please list any other drugs/materials that you are allergic to:

_____

5. Dental History

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

_____

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

Have you ever had a serious/difficult problem associated with any previous dental work?

☐ Yes ☐ No

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

Do you have any missing or extra permanent teeth?

☐ Yes ☐ No

Do you like your smile?

☐ Yes ☐ No

Do your gums ever bleed?

☐ Yes ☐ No

Do you have any speech problems?

☐ Yes ☐ No

Your current dental health is:

☐ Good ☐ Fair ☐ Poor

Have you ever had an injury to your:

☐ Mouth ☐ Teeth ☐ Chin

Do you generally breathe through your mouth?

☐ Yes ☐ No

☐ While Awake ☐ While Asleep

6. Patient Authorization

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature of patient

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature of patient

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature of patient

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Office Use Only

I verbally reviewed the medical information with the patient named herein.

Doctor's Comments: _____

_____

_____

Initials: _____ Date: ____/____/____