Adult Health History Form

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1. About You

Today's Date: _____ ☐ Female ☐ Male

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 visit: _____

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? ☐ Yes ☐ No Week#: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical conditions? (Check all that apply)

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

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

_____

Are you allergic to any of the following?

☐Aspirin	☐Penicillin	☐Dental Anesthetics
☐Latex	☐Tetracycline	☐Any Metals/Plastics
☐Codeine	☐Erythromycin	☐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: _____