ADULT HEALTH HISTORY FORM

Date:______________________

PATIENT INFORMATION

Patient's Name____DOB______________________Age________
Last First Middle
Name you would like to go by _________________________________
Patient's Home Address______________________________________City______________________State_______Zip________
Patient's Home Phone Number__________________________
E-Mail (used for appointment reminders, kept confidential)____
Employed by_____________________________Business Address__________________________Phone____________________
Occupation____
Social Security Number_____________________________________Driver's license number_________________________
Patient's Dentist______________________________Address____________________________________Ph#__________________
Names and Ages of Other Family Members____
Who may we thank for referring you to our office?____
Is the patient Single Married Divorced Widowed
Spouse's Name_______________________________________Employer/Occupation_______________________________
In Emergency Notify____
Name Address City State Zip Phone

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name_________________________________Address________________________________City_______________State_____Zip______
SS#________________________Daytime Phone________________________Evening Phone_______________________________
Cell Phone #____Email Address_____________________________________

INSURANCE INFORMATION

Primary Insurance Information Relationship to Patient______________________
Insured's Name____Insured's DOB_______________Insured SS#__________________
Employer's Name____Employer's Ph #____
Employer's Address_______________________________________City_______________________State________Zip______________
Insurance Company____City_______________________State________Zip______________
Insurance Ph #___________________________________Name of Dental Plan____

Secondary Insurance Information Relationship to Patient______________________
Insured's Name____Insured's DOB_______________Insured SS#__________________
Employer's Name____Employer's Ph #____
Employer's Address_______________________________________City_______________________State________Zip______________
Insurance Company____City_______________________State________Zip______________
Insurance Ph #___________________________________Name of Dental Plan____

DENTAL HISTORY

Dentist____Date of Last Visit_____________________________
Dentist's Address____________________________________City___________________State_________Zip_________Phone #____________
What concerns you most about your teeth?____
Does the patient want teeth straightened?____

Please circle the appropriate answer to the following questions, and explain if needed:
Yes No Have there ever been any injuries to the face, mouth or teeth?____
Yes No Have you ever been informed of missing, extra or chipped teeth?____
Yes No Have you ever had any abscessed teeth?____
Yes No Is any of your mouth sensitive to temperature or pressure?____
Yes No Do your gums bleed when you brush your teeth?____
Yes No Do you have any type of thumb or tongue habit?____

CONTINUED ON OPPOSITE SIDE

Yes No Have you ever had any speech therapy?____________________
Yes No Do you have TMJ?____________________
Yes No Are you aware of your jaw clicking or popping?____________________
Yes No Have you ever been told that you grind your teeth?____________________
Yes No Are you aware of clenching your teeth?____________________
Yes No Do you have "tension" headaches?____________________
Yes No Do you have "frequent" headaches?____________________
Yes No Do you brush your teeth daily? How many times?____________________
Yes No Do you floss your teeth daily?____________________
Who first noticed a possible orthodontic problem?____________________
Chief Concern for evaluation and information desired:____________________
Have x-rays been taken recently?____________________When?____________________

MEDICAL HISTORY

Reviewed with patient by____________________Date____________________

Physician____________________Date of Last Visit____________________
Physician's Address____________________City____________________State__________Zip__________

Please Circle Yes or No (If Yes, please fill in the details)
Yes No Are you taking any medication?____________________
Yes No Are you allergic to any medication?____________________
Yes No Are you presently under care of a physician____________________Do you have a history of a major illness?________
Yes No Have you ever had any major operation?__________ Yes No Ever been hospitalized?__________
Yes No Have you had your tonsils or adenoids removed?____________________
Yes No Have you had any of the following: Asthma________Allergies________Hayfever________Throat Infections________
Yes No Are you allergic to anything? If yes please describe____________________

Please circle the appropriate answer for the medical conditions below:

Yes	**No**	**Abnormal Bleeding**	**Yes**	**No**	**Endocrine Problems**	**Yes**	**No**	**Liver Disease**
Yes	**No**	**Tuberculosis**	**Yes**	**No**	**Anemia**	**Yes**	**No**	**Elipesy**
Yes	**No**	**Lung/Respiratory**	**Yes**	**No**	**AIDS**	**Yes**	**No**	**Arthritis**
Yes	**No**	**Glaucoma**	**Yes**	**No**	**HIV+**	**Yes**	**No**	**Blood Disorder**
Yes	**No**	**Heart Murmur**	**Yes**	**No**	**Nervous Disorders**	**Yes**	**No**	**Contact Lenses**
Yes	**No**	**Bone/Joint Disorders**	**Yes**	**No**	**Heart Problems**	**Yes**	**No**	**Pneumonia**
Yes	**No**	**Cancer/Tumor**	**Yes**	**No**	**Hepatitis-Type______**	**Yes**	**No**	**Prolonged Bleeding**
Yes	**No**	**Diabetes**	**Yes**	**No**	**Herpes**	**Yes**	**No**	**Hyperactive**
Yes	**No**	**High Blood Pressure**	**Yes**	**No**	**Rheumatic Heart**	**Yes**	**No**	**Thyroid Disease**
Yes	**No**	**Dizziness/Fainting**	**Yes**	**No**	**Emotional Problems**	**Yes**	**No**	**Sinusitis**
Yes	**No**	**Kidney Involvement**	**Yes**	**No**	**Other____________________**			

For Women Only: Are you pregnant?__________
Remarks:____________________
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BENEFITS OF ORTHODONTICS
Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth and in the general function of the teeth, and general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Patient/Parent Signature____________________Date____________________

OFFICE USE

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials: ________Date__________

Doctor's comments:
____
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