

MEDICAL HISTORY – ADULT

Patient's Name _____ Date _____

Patient's Doctor _____ Phone _____

Is your general health good at this time? Yes No

Are you currently under the care of a physician? Yes No

If yes, please explain:

Please list any medications, vitamins or other supplements you are currently taking:

If you are allergic to any medication, food or material (i.e. penicillin, sulfa, latex, etc.) please list:

Have you ever had a serious illness or been hospitalized? Yes No

If yes, please explain:

Have you ever been advised by your physician to take an antibiotic prior to dental treatments? Yes No

Have you had any history of, difficulty with, or diagnosis of any of the following?:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bones/Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Circulation | <input type="checkbox"/> High / Low blood pressure | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Kidney | <input type="checkbox"/> Tobacco/Drug use |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver | <input type="checkbox"/> Use of Phen-Fen or Redux |
| <input type="checkbox"/> Fever Blisters | | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing | | |

Please list any other problems here:

DENTAL HISTORY - ADULT

Patient's Dentist: _____ Phone: _____

Date of last dental visit: _____

Have there been any injuries to your face, mouth or teeth? Yes No

If yes, please explain:

Have you had or do you presently have any of the following habits: thumb or finger sucking, lip biting, snoring, grinding teeth, or mouth breathing? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Have you previously consulted an orthodontist? Yes No

Orthodontist Name:

Date:

Have you ever been treated for bad bite, TMJ or periodontal disease? Yes No

If so, by whom?

Is there anything you would like to change about your smile? Yes No

Please list the main reasons/concerns for consultation :

Has anyone else in the family had orthodontics? Yes No

Are you satisfied with the results? Yes No

I, the undersigned, have completed the health questionnaire and certify that the information is true and correct. I realize that it is my responsibility to inform this office of any changes in the patient's medical status. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING BECAUSE OF INADEQUATE INFORMATION. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest.

Patient Signature

Date

New Patient Information

Patient Name: _____
(First) (Last) (Name Called)

Birthday: _____ Email: _____

Home Phone: _____ Alternate Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M / F SSN: _____ Race: _____

Dentist: _____ Last Visit: _____

Have any medical problems? _____

How did you hear about us? _____

What about your smile would you like to change? _____

List family members that are currently in our practice: _____

Responsible Party Information

*Responsible Party Name: _____
(First) (Last) (Name Called)

*Birthday: _____ Email: _____

Home Phone: _____ Alternate Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M / F *SSN: _____ Relationship to Patient: _____

Do you have dental insurance that you would like us to verify orthodontic benefits for you? Yes / No

***Information required for verifying insurance benefits.**

*Insurance Company: _____

Group #: _____ *ID #: _____

*Ins. Phone #: _____ Employer: _____

Additional Information: _____