



ADULT HEALTH HISTORY

We would like to welcome you to our office!

Patient Name: _____	
Prefers to be addressed as: _____	Sex: M F
Date of Birth: ____ / ____ / ____	Age ____
Home Phone #: _____	Work Phone #: _____
Cell/ Pager / Other Phone #: _____	Email for appointment reminders: _____
Patient's Address: _____	
Street	City State Zip
Occupation: _____	Employed by: _____
<u>Circle</u> Marital Status: Single Married Separated Divorced Widowed	
Spouse's Name: _____	Employed by: _____
Spouse's Occupation: _____	Spouse's Work Phone #: _____
Patient's Dentist: _____	Date of Last Exam: __/__/__
Patient's Physician: _____	Date of Last Exam: __/__/__
Name (s) of other children seen in our office: _____	

Responsible Party Information

Person responsible for account: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
<u>Primary Insurance Co:</u>	
Dental Insurance Co: _____	Group #: _____ Ortho Coverage: Y N
Insured's Name: _____	SS#: _____ Birth Date: ____/____/____
<u>Secondary Insurance Co:</u>	
Dental Insurance Co: _____	Group #: _____ Ortho Coverage: Y N
Insured's Name: _____	SS#: _____ Birth Date: ____/____/____
Other Insurance Information: _____	

Patient's Dental History

What are the main concerns you would like orthodontics (braces) to accomplish? _____

With what aspect of orthodontic treatment are you most concerned? ___ Quality ___ Cost ___ Discomfort ___ Time
 Y N Has an orthodontist been consulted previously? If yes, please list name of orthodontist _____
 and date of consultation: _____

Has there ever been any orthodontic treatment for any other member of your family? Y N Children: (Dr. _____)
 Spouse (Dr. _____) Other family members (Dr. _____) Were you satisfied with the results? Y N
 Y N Have there been any injuries to your face, mouth or teeth? _____
 Y N Have you been informed of any missing or extra permanent teeth? _____
 Y N Are you aware of any sores, lumps or irritated areas in the mouth? _____
 Y N Do you play a musical instrument? Please list: _____
 Y N Do you have any speech problems? _____
 Y N Are you concerned about the appearance of your teeth? _____
 Y N Is there anything that you would like to change about your smile? _____
 Y N Do you brush daily?
 Y N Do you floss daily?
 Y N Thumb / Finger habit? Y N Lip sucking/ biting? Y N Nail biting?
 Y N Any popping, clicking or jaw pain? Y N Clenching / Grinding Teeth?

Patient's Medical History

Please describe your current physical health: Good Fair Poor
 Please list all drugs that you are currently taking: _____

Please list all drugs to which you are **allergic**: _____

Y N Are you currently under the care of a physician? _____
 Y N Have you had tonsils and/ or adenoids removed? Age: _____
 Y N Do you have any history of major illness? _____
 Y N Have you ever been advised by a physician to take an antibiotic prior to any dental treatments?
 Y N Have you ever received IV bisphosphonates such as Zometa (Zoledronate) or Pamidronate (Aredia)?
 If treated, please list the dates that bisphosphonates therapy was started and stopped: _____
 Y N Have you ever taken oral bisphosphonates such as Fosamax, Actonel or Boniva?
 If treated, please list the dates that oral bisphosphonates therapy was started and stopped: _____

WOMEN: Are you pregnant or considering pregnancy in the next 2 years? Y N Are you nursing? Y N
 Are you currently taking medication for Birth Control? Y N

Please circle if you have been treated for any of the following:

Y N Tuberculosis	Y N Respiratory Lung Disease	Y N ADD
Y N Endocarditis	Y N High Blood Pressure	Y N Kidney Trouble
Y N Heart Condition	Y N Hepatitis (type:)	Y N Liver Disease
Y N Heart Pacemaker	Y N Venereal Disease	Y N Psychiatric Treatment
Y N Heart Angina	Y N Herpes (oral cold sores)	Y N Drug Addiction
Y N Heart Attack (Coronary)	Y N Blood Disorders/Bleeding Problems	Y N Headaches
Y N Mitral Valve Prolapse	Y N Inflammatory Rheumatism	Y N Jaw Clicking
Y N Congenital Heart Disease	Y N Arthritis	Y N Allergies
Y N Artificial Heart Valve	Y N Ulcers	Y N Allergies to Metal
Y N Heart Surgery (date _____)	Y N Stroke	Y N Allergies to Latex
Y N Heart Murmur	Y N Anemia	Y N Jaw Pain
Y N Rheumatic Fever	Y N Asthma	Y N Tonsillitis
Y N Prosthetic (artificial) joint	Y N Epilepsy	Y N Emotional Problems
Y N X-Ray/Radiation (Cancer)Therapy	Y N Glaucoma	Y N Other: _____
Y N AIDS or HIV Positive	Y N Fainting Spells	_____
Y N Diabetes		

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I understand that where appropriate, Credit Bureau reports may be obtained. I authorize the Orthodontist to share pertinent treatment information with collaborating dentists and specialists. I authorize the billing of insurance for treatment procedures when appropriate.

Signature of Patient: _____ Date: _____
 Signature of Orthodontist: _____ Date: _____
 Annual Update: Date: _____ Initials: _____
 Date: _____ Initials: _____
 Date: _____ Initials: _____