

# 4

## MEDICAL HISTORY *continued*

**Your current physical health is:**  Good  Fair  Poor

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

Please explain: \_\_\_\_\_

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

Please list each one: \_\_\_\_\_

**For Women:** Are you using a prescribed method of birth control?  Yes  No

Are you pregnant?  Yes  No      Week #: \_\_\_\_\_

Are you nursing?  Yes  No

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

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

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

**Are you allergic to any of the following?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin             | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Metals/Plastics | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin       | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine             | <input type="checkbox"/> Y <input type="checkbox"/> N Latex              | <input type="checkbox"/> Y <input type="checkbox"/> 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 orthodontics to accomplish?  
\_\_\_\_\_

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

Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No

**Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?**  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No      Gums ever bleed?  Yes  No

Have you ever had an injury to your:  Mouth  Teeth  Chin (Please Circle)

Do you have any speech problems? \_\_\_\_\_

Do you generally breathe through your mouth?  Yes  No  
If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth?  Yes  No

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

Have you ever taken Phen-Fen?  Yes  No

Do you smoke or use tobacco in any form?  Yes  No



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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 \_\_\_\_\_

Date \_\_\_\_\_



### Thank you for filling out this form completely.

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 the office, use the services of one or more credit reporting services.

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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# WELCOME TO THE ORTHODONTIST

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Please fill out this form completely. The better we communicate, the better we can care for you.

## 1

### ABOUT YOU

Today's Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
APT/CONDO #:

CITY STATE ZIP  
 Single  Married  Divorced  Widowed  Separated

Hm #: (\_\_\_\_) \_\_\_\_\_ Cell/Other #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ DL #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are 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

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ SS #: \_\_\_\_\_

Cell: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## 3

### ORTHODONTIC INSURANCE

#### Primary

Orthodontic Coverage:  Yes  No Dental Coverage:  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

#### Secondary

Orthodontic Coverage:  Yes  No Dental Coverage:  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

## 4

### MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

CONTINUED ON BACK