Health History Adult

Patient Name: ______________________________________Date: ____________________
Referred By: _______________________________________

Dentist's Name: ____
Date of last dental visit: ___________What service was performed? ___________________
What are the main concerns that you would like orthodontics to accomplish? ___________
____
____
Please describe your current dental health: Good Fair Poor
Do you like your smile? ___________Y/N Do your gums ever bleed? __________ Y/N
Have you ever had a serious/difficult problem associated with previous dental work?_____ Y/N
Have you ever been prescribed Fosamax or any other bisphosphonate? _________________ Y/N
Have you ever taken Phen-Fen? ____ Y/N
Have you been evaluated or had orthodontic treatment before?________________________ Y/N
Have there been any injuries to the face, mouth, teeth or chin?________________________ Y/N
Have you been informed of any missing or extra permanent teeth?_____________________ Y/N
Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ/TMD)?____ Y/N
Do you smoke or use tobacco in any form? ____ Y/N
Do you generally breathe through your mouth?_____________________________________ Y/N
If yes please circle: While Awake? While Asleep?

Physician's Name: ____
Date of last visit? ________________Are you currently under the care of a physician? ____ Y/N
If yes please explain:____
Please describe your child current physical health: Good Fair Poor
Please list all medications prescription/over-the-counter you are currently taking:_________
____
For Women: Are you using a prescribed method of birth control? _____________________ Y/N
Are you pregnant?_________________ Y/N Week number? ___________________
Are you nursing?__________________ Y/N

Have you ever had any of the following medical problems?

Abnormal Bleeding________________ Y/N
Anemia __________________________ Y/N
Artificial Bones/Joints/Valves ______ Y/N
Asthma/Arthritis __________________ Y/N
Blood transfusion _________________ Y/N
Cancer/Chemotherapy______________ Y/N
Congenital Heart Defect ____________ Y/N
Diabetes_________________________ Y/N
Difficulty Breathing _______________ Y/N
Drug/Alcohol Abuse _______________ Y/N

Hemophilia _______________________ Y/N
Hepatitis _________________________ Y/N
High/Low Blood Pressure___________ Y/N
HIV+/AIDS_______________________ Y/N
Hospitalized for Any Reason _______ Y/N
Kidney Problems__________________ Y/N
Mitral Valve Prolapse ______________ Y/N
Psychiatric Problems_______________ Y/N
Radiation Treatment _______________ Y/N
Rheumatic/Scarlet Fever____________ Y/N

Emphysema______________________ Y/N
Epilepsy/Seizures/Fainting _________ Y/N
Fever Blisters/Herpes _____________ Y/N
Glaucoma _______________________ Y/N
Heart Attack/Stroke ______________ Y/N
Heart Murmur ____________________ Y/N
Heart Surgery/Pacemaker __________ Y/N
Severe/Frequent Headaches ________ Y/N
Shingles_________________________ Y/N
Sickle Cell Disease/Traits__________ Y/N
Sinus Problems ___________________ Y/N
Tuberculosis (TB) ________________ Y/N
Ulcers/Colitis ____________________ Y/N
Venereal Disease__________________ Y/N

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

Are you allergic to any of the following?

Aspirin_______________Y/N Dental Anesthetics _______Y/N Penicillin ____________ Y/N
Any Metals/Plastics ____Y/N Erythromycin ___________Y/N Tetracycline __________ Y/N
Codeine ______________Y/N Latex __________________Y/N Other _______________ Y/N

Please list any other drugs/materials that you are allergic to:__________________________
____

I understand that the information that I have given is correct to the best of my knowledge, that it 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 Date

I understand that this office will file insurance with any company except Sooner Care, Medicaid and Medicare. I understand that I am ultimately responsible for payment of any services rendered including co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize release of any information relating to this claim. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____ ______________________

Signature of Patient Date

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 service.

____ ______________________

Signature of Patient 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.