



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

Insured's Name _____ Relationship to Patient _____
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

Insured's Name _____ Relationship to Patient _____
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: _____

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:
