ADULT HEALTH HISTORY FORM

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ _____ _____ Female / Male M / D / S
Last First Middle Sex Marital Status

Address _____ _____ _____ _____
Street City State Zip Code

Birth Date _____ Email _____ Social Security # _____

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office? _____

Spouse / Additional Contact Information

Name _____ _____ _____ M / D / S
Last First Middle Marital Status

Address _____ _____ _____ _____
Street City State Zip Code

Birth Date _____ Email _____ Social Security # _____

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____

Employer _____ Occupation _____ No. Years Employed _____

Medical History

Are you under the care of a physician? ☐ Yes ☐ No If Yes, please explain: _____

Physician _____ Phone _____ Date of Last Visit _____

Address _____

Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Have you ever experienced jaw joint pain / discomfort (TMJ/TMD)? ☐ Yes ☐ No

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

Have you ever had an injury to (select all that apply): ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No If Yes, please explain: _____

Do your gums bleed? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Do/Have you ever had any of the following habits?	☐ Lip Sucking/Biting	☐ Nail Biting	☐ Prolonged Bottle/Pacifier
☐ Clenching/Grinding teeth	☐ Mouth breather	☐ Tongue Thrusting	☐ Thumb/Finger Sucking

Are you allergic to any of the following?	List all drugs you are currently taking.	List any serious medical conditions.
☐ Aspirin ☐ Erythromycin ☐ Codeine ☐ Penicillin ☐ Tetracycline ☐ Latex ☐ Any Metals/Plastics Other Allergies/Sensitivities:		

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out his form _____ Date _____