



## PATIENT HEALTH HISTORY ADULT

PATIENT'S NAME: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Nickname: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Preferred way to be contacted: ☐ Call ☐ Email ☐ Mail ☐ Text ☐ Other: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Children (Names & DOB): \_\_\_\_\_

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Other \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

### DENTAL INSURANCE

Primary Insurance Company: \_\_\_\_\_ Contract #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured's Address if different from above: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ortho Coverage? ☐ Yes ☐ No

Secondary Insurance Company: \_\_\_\_\_ Contract #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured's Address if different from above: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ortho Coverage? ☐ Yes ☐ No

### DENTAL HISTORY

Patient's Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Referred by: ☐ Dentist ☐ Facebook ☐ Google ☐ Billboard Ad ☐ Radio Ads ☐ Friend/Patient: Name: \_\_\_\_\_ ☐ Other: \_\_\_\_\_

Reason for consultation (Chief Concern): \_\_\_\_\_ Preferred method of treatment: ☐ Braces ☐ Clear Aligners ☐ Doctors Choice

What aspect of orthodontic treatment is the patient most concerned about? ☐ Quality ☐ Cost ☐ Discomfort ☐ Time

☐ Yes ☐ No Has an orthodontist been consulted previously? Name: \_\_\_\_\_ Date: \_\_\_\_\_

☐ Yes ☐ No Have there been any injuries to the face, mouth or teeth?

☐ Yes ☐ No Has the patient had or presently have any of the following habits? Check all that apply.

☐ Thumb or Finger Sucking ☐ Lip Biting ☐ Snoring ☐ Grinding Teeth at Night ☐ Mouth Breathing

☐ Yes ☐ No Has the patient been informed of any missing or extra teeth?

☐ Yes ☐ No Is the patient aware of any sores, lumps or irritated areas in the mouth?

☐ Yes ☐ No Has the patient been treated for: ☐ Bad Bite ☐ TMJ ☐ Periodontal Disease

- ☐ Yes ☐ No Is the patient frightened or anxious about orthodontic treatment?
- ☐ Yes ☐ No Is the patient concerned about the appearance of their teeth? Explain: \_\_\_\_\_

## MEDICAL HISTORY

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- ☐ Yes ☐ No Is your general health good at this time? Primary Doctor: \_\_\_\_\_ Last Exam: \_\_\_\_\_
- ☐ Yes ☐ No Are you taking any medication? Name: \_\_\_\_\_
- ☐ Yes ☐ No Are you allergic to any medication? (Penicillin, Sulfa, etc.) Name: \_\_\_\_\_
- ☐ Yes ☐ No Have you had tonsils and/adenoids removed? Age: \_\_\_\_\_
- ☐ Yes ☐ No Have you ever had a serious illness or been hospitalized? Explain: \_\_\_\_\_
- ☐ Yes ☐ No Do you have any special problems not listed? Explain: \_\_\_\_\_
- ☐ Yes ☐ No Have you ever been advised by a physician to take an antibiotic prior to any dental treatments?
- If yes, antibiotic name and method: \_\_\_\_\_
- ☐ Yes ☐ No Do you use tobacco products?

**For Women: Are you pregnant?** ☐ Yes ☐ No **– Are you considering pregnancy in the next two years?** ☐ Yes ☐ No

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Do you have or have you ever had any of the following?

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> AIDS or H.I.V. Positive  | <input type="checkbox"/> Chronic Sinusitis              | <input type="checkbox"/> Heart Condition: _____   | <input type="checkbox"/> Osteoporosis/ Bisphosphonates? |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Hepatitis; Type _____    | <input type="checkbox"/> Pregnant                       |
| <input type="checkbox"/> Allergies to Latex       | <input type="checkbox"/> Drug Addiction                 | <input type="checkbox"/> Herpes (Oral-Cold Sores) | <input type="checkbox"/> Prosthetics                    |
| <input type="checkbox"/> Allergies to Metal       | <input type="checkbox"/> Earaches                       | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Radiation Therapy              |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Eating Disorder                | <input type="checkbox"/> Inflammatory Rheumatism  | <input type="checkbox"/> Respiratory Lung Disease       |
| <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Emotional/Mental Health Issues | <input type="checkbox"/> Jaw Clicking/Jaw Pain    | <input type="checkbox"/> Rheumatic Fever                |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Kidney Trouble           | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Fainting Spells                | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Ulcers                         |
| <input type="checkbox"/> Blood Disorder           | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Other : _____                  |
|   | <input type="checkbox"/> Heart Attack (Coronary)        |   |   |

I, 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 treatment in the patient's best interest. I understand that, when appropriate, Credit Bureau reports may be obtained. I authorize the orthodontist to share pertinent treatment information with collaborating dentists and surgeons when appropriate. I authorize the orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

**Signature of Patient:** \_\_\_\_\_

I acknowledge receipt of Prestwich Orthodontics Notice of Privacy Practices (You may refuse to sign this acknowledgement):

**Signature of Patient:** \_\_\_\_\_ Today's Date: \_\_\_\_\_

### For office use only:

Signature of Office Witness: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Bracket Choice:** ☐ Stainless \_\_\_\_\_ ☐ Clear Aligners \_\_\_\_\_ ☐ Clear Braces