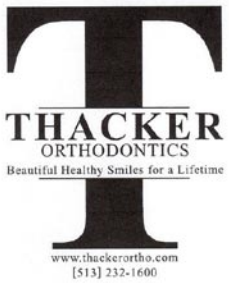
ADULT HEALTH HISTORY FORM



Patient Name: _____ **Nickname:** _____

Birth date: _____/_____/_____ **Patient age:** _____**yrs.** _____**mos.** **Sex:** □ **male** □ **female**

Children Names:_____ **Ages:** _____

Address: _____ **Home Phone:** (_____) _____-_____

General Dentist: _____ **Office phone:** (_____) _____-_____

If other than your dentist, who can we thank for referring you to our office? _____

LIST ANY KNOWN ALLERGIES: _____ **SENSITIVITY TO LATEX? YES □ NO □**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES ***COPY OF HIPPA PRIVACY DISCLOSURE WILL BE PROVIDED UPON REQUEST***

Print Name:_____ ***Signature***_____ ***Date:*** ___/___/_____

You may refuse to sign this acknowledgement

RESPONSIBLE PARTY INFORMATION ***This office reserves the right to verify the credit status of potential patients seeking payment terms.***

Patient Full Name: _____ Address: _____

(City/State/Zip)_____ How long at this address? _____

Rent □ Own □ Home Phone: ( ) _____Work Phone: ( ) _____

Cell Phone: (_____)_____ E-mail address: _____@_____

Social Security Number: _____-_____-_____ **(*must be provided to verify insurance coverage*)** Birth date: ___/___/___

Employer_____Occupation_____Years employed_____

Spouse (Partner) Name: _____

Work Phone: (_____)_____ Cell Phone: (_____)_____ E-mail address: _____@_____

Social Security Number: _____-_____-_____ **(*must be provided to verify insurance coverage*)** Birth date: ____/____/____

Spouse Employer_____Occupation_____Years employed_____

DENTAL INSURANCE INFORMATION ONLY ***(Must provide copy of insurance card to our***

Do you have DENTAL INSURANCE? □ **Yes** □ **No** If yes, **Primary Insurance Company**:_____

Insurance Company Address_____ Insurance Co. City/State/Zip _____

Insurance Co. Phone No. ( ) _____ Name of Employer _____

Group No._____ ID #_____

Employee Name _____ Date of Birth_____/_____/_____

Employee Home Address (if different than patient) _____ City/State/Zip_____

Employee relationship to patient _____ Employee Social Security # _____

Do you have Secondary Insurance? If yes, **Secondary Insurance Company** _____

Insurance Co. Address_____ Insurance Co. City/State/Zip _____

Insurance Co. Phone ( ) _____ Name of Employer _____

Group No._____ ID #_____

Employee Name _____ Date of Birth_____/_____/____

Employee Home Address (if different than patient) _____City/State/Zip _____

Employee relationship to patient _____ Employee Social Security # _____

Name of emergency contact (not living in your home) _____ Phone: (_____) _____

Complete Address: _____City/State/Zip_____Relationship:_____

The above information is correct to the best of my knowledge.

Signature _____ ***Date*** _____/_____/_____ ***Relationship to patient***_____

***PLEASE SEE OTHER SIDE TO COMPLETE HEALTH HISTORY FORM** over----------→**

MEDICAL HISTORY

Is this patient in Good health? _____ ☐ Yes ☐ No

Does patient have a history of major illness? _____ ☐ Yes ☐ No

Has patient been under the care of a physician for a major illness: ☐ Yes ☐ No

List any known allergies _____ Sensitivity to latex? ☐ Yes ☐ No

ASTHMA	☐ yes	☐ no	CANCER	☐ yes	☐ no	HIGH BLOOD PRESSURE	☐ yes	no ☐
DIABETES	☐ yes	☐ no	ANEMIA	☐ yes	☐ no	PROLONGED BLEEDING	☐ yes	no ☐
PNEUMONIA	☐ yes	☐ no	EPILEPSY	☐ yes	☐ no	FAINTING OR DIZZINESS	☐ yes	no ☐
HEART PROBS.	☐ yes	☐ no	NERVOUS DISORDER	☐ yes	☐ no	LIVER INVOLVEMENT	☐ yes	no ☐
RHEUMATIC FEVER	☐ yes	☐ no	TUBERCULOSIS	☐ yes	☐ no	KIDNEY INVOLVEMENT	☐ yes	no ☐
BONE DISORDERS	☐ yes	☐ no	ADD/ADHD	☐ yes	☐ no	ENDOCRINE PROBLEMS	☐ yes	no ☐
HEPATITIS	☐ yes	☐ no	AIDS/HIV	☐ yes	☐ no	VENERAL DISEASE	☐ yes	no ☐

If yes to any of the above, please explain _____

Have tonsils and adenoids been removed? ☐ yes ☐ no What age? _____

List any drugs or medications now being taken. Give reason: _____

Has patient reached puberty? ☐ Girl ☐ yes ☐ no Has menstruation started? ☐ yes ☐ no

☐ Boy ☐ yes ☐ no Has voice changed? ☐ yes ☐ no

If female, are you pregnant? ☐ yes ☐ no TMJ/TMD Symptoms ☐ yes ☐ no _____

History of headaches? ☐ yes ☐ no Any other medical concerns? _____

GENERAL

Previous orthodontic treatment _____

What concerns you most about your teeth and facial appearance? _____

Have other members of your family had orthodontic treatment? _____

Has anyone in your family been seen in our office? Name(s) _____

Does anyone in your family have a similar dental problem? _____

Number of children _____ Name(s) _____ Age(s) _____

DENTAL HISTORY

Have there been injuries to the face mouth or teeth? ☐ yes ☐ no

Has the patient ever sucked a thumb or finger? Until what age? ☐ yes ☐ no

Does the patient have any speech problems? ☐ yes ☐ no

Have you been informed of any missing or extra teeth? ☐ yes ☐ no

Has an orthodontist been consulted previously? ☐ yes ☐ no

Has either parent or patient had orthodontic treatment? ☐ yes ☐ no

Chief concern: _____

The above information is correct to the best of my knowledge.

Signature _____ ***Date*** _____