Medical Dental History Form for Adult Patients

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My Life. My Smile. My Orthodontist.®

CONFIDENTIAL

PATIENT

Date _____
Patient's last name _____ First name _____Middle initial_____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____
Birth date _____ Sex: Male Female Social Security #_____
Marital Status Single- Married -Separated -Divorced- Widowed
Home address _____ City, State, Zip code_____
Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____
Email Address(es) _____
Occupation _____ Employer _____

CLOSEST RELATIVE OR SPOUSE

Spouse or closest relatives name(s)_____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient_____
Address *(if different than patient address)* _ _____
Home Phone *(If different)* ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

DENTIST

Patient's Dentist _____ Address, City, State_____
Last seen _____ Reason _____ Next appointment _____
Other dentists/dental specialists now being seen: Name_____ City, State _____
Reason_____

FINANCIAL RESPONSIBILITY

Billing Party Name: _____
Address *(if different than above)* _____ City, State, Zip_____
Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address_____
Social Security #_____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date_____
Social Security #_____ Relationship to patient_____
Address and phone (if not listed above) _____
Employer _____ Address_____
Insurance company_____ Group # _____ ID#_____
Does this policy have orthodontic benefits? Yes No Don't Know

Secondary policy holder's full name _____ Birth date_____
Social Security #_____ Relationship to patient_____
Address and phone (if not listed above) _____
Employer _____ Address_____
Insurance company_____ Group # _____ ID#_____
Does this policy have orthodontic benefits? Yes No Don't Know

General Information

What concerns you about your teeth?_____
Who suggested that you might need orthodontic treatment?_____
Why did you select our office?_____
Have you had any previous orthodontic treatment? Please describe._____
Have any other family members been treated in this office? Please name them._ _____
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain

_____

Whom can we thank for referring you to our practice:_____

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you tak
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Have you ever taken any medications to strengthen your bones? Please describe._____

_____

Do you take antibiotic pre-medication before any dental procedures?_____
Do you or have you ever had a substance abuse problem? _____
Do you chew or smoke tobacco? _____
Have you noticed any changes in your face or jaws? _____
Any other physical problems? _ _____
How often do you brush? _____ How often do you floss? _____
Women: Are you pregnant? Yes No Are you trying to become pregnant? Yes No

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental heal

Signature _____ Date _____

***NOTE: Orthodontic Specialists, LLC will send a copy of your orthodontic treatment to your insurance company as a courtesy to you. Insurance payments may vary depending on your employer and your insurance policy. Please notify our office immediately of any changes to your insurance coverage, policy or employment.*

AUTHORIZATIONS
I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted by law. I consent to your use and disclosure of protected health information to carry out payment activities in connection with this claim.

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluatior

For the following questions, please mark yes, no, or don't know/understand (dk/u).

Y N DK

☐ ☐ ☐ Birth defects or hereditary problems?
☐ ☐ ☐ Bone fractures or major injuries?
☐ ☐ ☐ Any injuries to face, head, neck?
☐ ☐ ☐ Arthritis or joint problems?
☐ ☐ ☐ Endocrine or thyroid problems?
☐ ☐ ☐ Diabetes or low sugar?
☐ ☐ ☐ Kidney problems?
☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
☐ ☐ ☐ Immune system problems?
☐ ☐ ☐ History of osteoporosis?
☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ ☐ ☐ AIDS or HIV positive?
☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
☐ ☐ ☐ Mental health disturbance or depression?
☐ ☐ ☐ Vision, hearing, or speech problems?
☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
☐ ☐ ☐ High or low blood pressure?
☐ ☐ ☐ Excessive bleeding or bruising, anemia?
☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
☐ ☐ ☐ Skin disorder (other than common acne)?
☐ ☐ ☐ Do you eat a well-balanced diet?
☐ ☐ ☐ Frequent headaches or migraines?
☐ ☐ ☐ Frequent ear infections, colds, throat infections?
☐ ☐ ☐ Asthma, sinus problems, hay fever?
☐ ☐ ☐ Tonsil or adenoid condition?
☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

Y N DK

☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
☐ ☐ ☐ Latex (gloves, balloons)
☐ ☐ ☐ Aspirin
☐ ☐ ☐ Ibuprofen (Motrin, Advil)
☐ ☐ ☐ Penicillin
☐ ☐ ☐ Other antibiotics
☐ ☐ ☐ Metals (jewelry, clothing snaps)
☐ ☐ ☐ Acrylics
☐ ☐ ☐ Plant pollens
☐ ☐ ☐ Animals
☐ ☐ ☐ Foods
☐ ☐ ☐ Other substances _____

Dental History

Now or in the past, have you had:

Y N DK

☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
☐ ☐ ☐ Chipped or injured primary or permanent teeth?
☐ ☐ ☐ Any sensitive or sore teeth?
☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
☐ ☐ ☐ Jaw fractures, cysts, infections?
☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
☐ ☐ ☐ History of speech problems or speech therapy?
☐ ☐ ☐ Difficulty breathing through nose?
☐ ☐ ☐ Food impaction between the teeth?
☐ ☐ ☐ Mouth breathing habit or snoring at night?
☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
☐ ☐ ☐ Tooth grinding or clenching?
☐ ☐ ☐ Clicking, locking in jaw joints?
☐ ☐ ☐ Soreness in jaw muscles or face muscles?
☐ ☐ ☐ Ringing in ears, difficulty in chewing or opening jaw?
☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" problems?
☐ ☐ ☐ Any broken or missing fillings?
☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment before now?

I have received a copy of this office's Notice of Privacy Practices.

Patient Name:_____

Patient or Responsible Party Signature:_____

Date:_____

You May Refuse to Sign This Acknowledgment

I agree that the orthodontic practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 435-673-9661.

Email Address:_____@_____

Patient or Responsible Party Signature:_____

General Photography Release

I hereby authorize Orthodontic Specialists to publish photographs taken of me, or my child, for use in Orthodontic Specialists photo and video based marketing materials, as well as other company publications.

I hereby release and hold harmless Orthodontic Specialists from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Orthodontic Specialists, and the employees involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Patient Name:_____

Responsible Party Signature:_____ Date_____