# ADULT HEALTH HISTORY AND CONSENT/PATIENT INFORMATION

***The benefits of a happy, healthy smile are immeasurable!*** *A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.*

MARTIN ORTHODONTICS
Jeffrey A. Martin, DMD, MS

**ABOUT YOU** ❑ Male ❑ Female Today's date _____

Name _____ Birthdate _____

I prefer to be called _____ SS # _____

Home phone _____ Work _____ Mobile _____

Mobile carrier *(for text reminders)* _____ Email _____

Best way to reach you ❑ Home ❑ Work ❑ Cell ❑ Email

Home address _____City_____ State_____ Zip _____

Employer's name _____

Referred by? _____ Other family members seen by us _____

General dentist _____ Date of last visit _____

**SPOUSE INFORMATION**

Name _____ Birthdate _____

Employer's name _____

**PERSON RESPONSIBLE FOR ACCOUNT**

Name _____ Birthdate _____

Home phone _____ Work _____ Mobile_____

Billing address _____ City _____ State _____ Zip_____

Relation to patient _____ SS# _____ Employer's name_____

**PRIMARY INSURANCE** Orthodontic coverage ❑ Yes ❑ No Dental coverage ❑ Yes ❑ No

Insurance company name _____ Phone _____

Insurance company address _____ City _____ State ____ Zip_____

ID # _____ Group # _____

Policy holder's name _____ Relation _____ Birthdate _____

Policy holder's employer _____ Policy holder's SS# _____

**MEDICAL HISTORY** **Do you have a personal physician?** ❑ Yes ❑ No Date of last visit _____

Physician's name _____ Phone _____

**DENTAL HISTORY** **Current dental health is:** ❑ Good ❑ Fair ❑ Poor **Do you like your smile?** ❑ Yes ❑ No

**What main concerns would you like Martin Orthodontics to address?** _____

_____

**Have you ever:** · been evaluated or received orthodontic treatment? ❑ Yes ❑ No

· had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No_____

· had any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No _____

· had pain/tenderness in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Do you have any speech problems? ❑ Yes ❑ No *(specify)*_____

Do you generally breathe through your mouth? ❑ Yes ❑No If yes, please indicate: ❑ While awake ❑ While asleep

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

Have you ever taken Fosamax or any other bisphosphonate? ❑ Yes ❑No Smoker/tobacco user *(in any form)* ❑ Yes ❑ No

**YOUR HISTORY** **Describe your current physical health:** ❑ good ❑ fair ❑ poor

Are you currently under the care of a physician? ❑ Yes ❑No Explain _____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No Please list each one: _____

_____

**For Women only:** Are you pregnant? ❑ Yes ❑ No Week # _____ Are you nursing? ❑ Yes ❑ No

**Have you ever had any of the following diseases or medical problems?** ***(circle one)***

| | | | |
|---|---|---|---|
| Y N abnormal bleeding | Y N drug/alcohol abuse | Y N hepatitis | Y N shingles |
| Y N anemia | Y N emphysema | Y N HIV+ / AIDS | Y N sickle cell disease/traits |
| Y N asthma | Y N epilepsy/seizures/fainting | Y N hospitalized for any reason | Y N sinus problems |
| Y N arthritis | Y N fever blisters/herpes | Y N kidney problems | Y N tuberculosis (TB) |
| Y N blood transfusion | Y N glaucoma | Y N mitral valve prolapse | Y N ulcers/colitis |
| Y N cancer/chemotherapy | Y N heart attack/stroke | Y N psychiatric problems | Y N venereal disease |
| Y N congenital heart defect | Y N heart murmer | Y N radiation treatment | |
| Y N diabetes | Y N heart surgery/pacemaker | Y N rheumatic/scarlet fever | |
| Y N difficulty breathing | Y N hemophilia | Y N severe/frequent headaches | |

Please list any serious medical conditions that you have ever had _____

_____

**Are you allergic to any of the following?**

| | | |
|---|---|---|
| Y N aspirin | Y N dental anesthetics | Y N penicillin |
| Y N any metals/plastics | Y N erythromycin | Y N tetracycline |
| Y N codeine | Y N latex | Y N other |

Please list any other drugs/materials that you are allergic to _____

**AUTHORIZATION**

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

***I authorize the dental staff to perform the necessary dental services I may need during diagnosis and treatment with my informed consent.***

Signature _____ Date _____

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**Doctor's Comments:**

_____

_____

_____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ Date _____