

# 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.*

## 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 murmur	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 \_\_\_\_\_

----- -OFFICE USE ONLY- -----

**Doctor's Comments:**

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

Initials \_\_\_\_\_ Date \_\_\_\_\_