Adult New Patient Health History

Medical History

Do you have a physician? ☐ yes ☐ no
Physician's Name? _____

Phone #: (____)_____
Date of last visit? : _____

Your current physical health is:
☐ good ☐ fair ☐ poor

Are you currently under the care of a physician?
☐ yes ☐ no
Please explain: _____
_____

Are you taking any prescription/over the counter drugs? ☐ yes ☐ no
Please list each one: _____
_____

For women: Are you using a prescribed method of birth control?
☐ yes ☐ no
Are you pregnant? ☐ yes ☐ no
Week #: _____
Are you nursing? ☐ yes ☐ no

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____
_____
_____

Have you ever had or been evaluated for orthodontic treatment?
☐ yes ☐ no
Have you ever had a serious/difficult problem associated with any previous dental work?
☐ yes ☐ no
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
☐ yes ☐ no
Your current dental health is:
☐ good ☐ fair ☐ poor
Do you like your smile? ☐ yes ☐ no
Gums ever bleed? ☐ yes ☐ no
Have you ever had an injury to your:
○ Mouth ○ teeth ○ chin
Do you have any speech problems? _____
_____

Do you generally breathe through your mouth?
☐ yes ☐ no
If yes, please circle: While awake? While asleep?
Do you have any missing or extra permanent teeth?
☐ yes ☐ no
Do you smoke or use tobacco in any form?
☐ yes ☐ no

Have you ever had any of the following diseases or medical problems?

☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Anemia
☐ Y ☐ N Artificial Bones/ Joints/Valves
☐ Y ☐ N Asthma/Arthritis
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer/Chemotherapy
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Diabetes
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Drug/Alcohol Abuse
☐ Y ☐ N Emphysema
☐ Y ☐ N Epilepsy/Seizures/Fainting
☐ Y ☐ N Fever Blisters/Herpes
☐ Y ☐ N Glaucoma
☐ Y ☐ N Heart Attack/Stroke
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Surgery/Pacemaker
☐ Y ☐ N Hemophilia
☐ Y ☐ N Hepatitis
☐ Y ☐ N High/Low Blood Pressure
☐ Y ☐ N HIV+/Aids
☐ Y ☐ N Hospitalized for Any Reason
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Rheumatic/Scarlet Fever
☐ Y ☐ N Severe/Frequent Headaches
☐ Y ☐ N Shingles
☐ Y ☐ N Sickle Cell Disease/Traits
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Ulcers/Colitis
☐ Y ☐ N Venereal Disease

Please list any serious medical condition(s) 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:_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

Signature Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature Date

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.