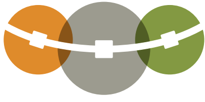

about faces and braces
ORTHODONTICS

ADULT HISTORY FORMS

Patient Information

NAME:	GENDER:	DATE:	
SSN:	BIRTHDATE:	AGE:	
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
AT YOUR HOME ADDRESS, DO YOU: ○ RENT ○ OWN	PRIMARY PHONE NUMBER:		
HOW LONG HAVE YOU LIVED AT YOUR CURRENT ADDRESS? (REQUIRED)			
PREVIOUS ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE TYPE: ○ HOME ○ CELL	OK TO LEAVE MESSAGE?: ○ YES ○ NO		
EMAIL:	EMPLOYER'S NAME:		
OCCUPATION:	HOW LONG HAVE YOU WORKED AT YOUR CURRENT JOB? (REQUIRED)		
SPOUSE/PARTNER'S NAME:	MARITAL STATUS:	SN:	
BIRTHDATE:	DRIVER'S LICENSE NUMBER:		
ADDRESS (IF DIFFERENT THAN PATIENT)	CITY:	STATE:	ZIP CODE:
PRIMARY PHONE NUMBER:	PHONE TYPE: ○ HOME ○ CELL		
SECONDARY PHONE NUMBER:	PHONE TYPE: ○ HOME ○ CELL		
EMERGENCY CONTACT'S NAME:	PHONE NUMBER:	RELATION TO PATIENT:	

Primary Dental Insurance and Dental History (Please do NOT provide medical Insurance)

PRIMARY INSURANCE COMPANY:	PHONE NUMBER:	
SUBSCRIBER NAME:		
SUBSCRIBER NUMBER:	POLICY HOLDER'S SSN:	POLICY HOLDER'S DATE OF BIRTH:
GENERAL DENTIST:	DATE LAST VISIT:	
HOW DID YOU HEAR ABOUT OUR PRACTICE:		
NAME OF PERSON REFERRING (IF APPLICABLE)		
WHAT ARE THE MAIN CONCERNS YOU WOULD LIKE ORTHODONTICS TO CORRECT?		

HAVE YOU VISITED AN ORTHODONTIST BEFORE?	◯ YES	◯ NO
HAVE YOUR TONSILS OR ADENOIDS BEEN REMOVED?	◯ YES	◯ NO
HAVE YOU EVER EXPERIENCED JAW JOINT PAIN/DISCOMFORT (TM J/TM D)?	◯ YES	◯ NO
DO YOU HAVE ANY MISSING OR EXTRA PERMANENT TEETH?	◯ YES	◯ NO
HAVE YOUR EVER HAD AN INJURY TO TEETH, MOUTH, OR CHIN?	◯ YES	◯ NO
DO YOU HAVE SPEECH PROBLEMS?	◯ YES	◯ NO
DO YOUR GUMS BLEED?	◯ YES	◯ NO
DO YOU SMOKE?	◯ YES	◯ NO
DO YOU LIKE YOUR SMILE?	◯ YES	◯ NO

DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY OF THE FOLLOWING HABITS (CHECK ALL THAT APPLY)

◯ CLENCHING/GRINDING TEETH	◯ LIP SUCKING/BITING	◯ MOUTH BREATHING
◯ NAIL BITING	◯ THUMB/FINGER SUCKING	◯ CHEWING/EATING PROBLEM

Medical History

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN?	◯ YES	◯ NO
NAME OF PRIMARY CARE PHYSICIAN:		
REASON FOR LAST VISIT:		
ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS?	◯ YES	◯ NO
IF YES, PLEASE LIST WITH THE DOSAGE:		
HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? IF YES, DESCRIBE	◯ YES	◯ NO
HAVE YOU EVER HAD BLOOD TRANSFUSION? IF YES, GIVE APPROXIMATE DATES	◯ YES	◯ NO
(WOMEN) ARE YOU PREGNANT?	◯ YES	◯ NO

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

◯ ANEMIA	◯ COUGHING BLOOD	◯ KIDNEY DISEASE	◯ TONSILLITIS
◯ ARTHRITIS, RHEUMATISM	◯ DIABETES	◯ LIVER DISEASE	◯ TUBERCULOSIS
◯ ARTIFICIAL HEART VALVES	◯ EPILEPSY	◯ MISTRAL VALVE PROLAPSE	◯ ULCER
◯ ARTIFICIAL JOINTS	◯ FAINTING	◯ PACEMAKER	◯ VENEREAL DISEASE (STD)
◯ ASTHMA	◯ GLAUCOMA	◯ RADIATION TREATMENT	
◯ BACK PROBLEMS	◯ HEADACHES	◯ RESPIRATORY DISEASE	
◯ BLOOD DISEASE	◯ HEART MURMUR	◯ RHEUMATIC FEVER	
◯ CANCER	◯ HEART PROBLEMS	◯ SCARLET FEVER	
◯ CHEMICAL DEPENDENCY	◯ HEMOPHILIA	◯ SHORTNESS OF BREATH	
◯ CHEMOTHERAPY	◯ HEPATITIS	◯ SKIN RASH	
◯ CIRCULATORY PROBLEMS	◯ HIGH BLOOD PRESSURE	◯ STROKE	
◯ CORTISONE TREATMENTS	◯ HIV/AIDS	◯ THYROID PROBLEMS	
◯ COUGH, PERSISTENT	◯ JAW PAIN	◯ TOBACCO HABIT	

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 of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE:____ DATE:____________________