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Medical/Dental History Form - Adult Intake Form

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE
The information you provide in this packet is vital and will assist the doctor during the review of your symptoms. Please respond to all questions. Questions contained within are confidential and will become a part of your child's healthcare record. Some questions are intended for governmental/statistical purposes only.

PATIENT INFORMATION
Name: ____ Sex: F ◯ M ◯
Last First Middle Initial

____
Home Address City State Zip Code

_______/_______/_______ ________ ________ ________________________________
Date of Birth Height Weight Email Address

Social Security Number: __________ - ______ - _________

PATIENT CONTACT INFORMATION
Primary phone number: ___________________________ Home ◯ Mobile ◯ Work ◯ Other ◯
Alternate phone number: ___________________________ Home ◯ Mobile ◯ Work ◯ Other ◯
PREFERRED CONTACT: Phone ◯ Text ◯ Email ◯ Other ◯ ______________________________

CONTACT & DISCLOSURE INFORMATION
Please provide contact name in case of an Emergency:

____________________________ ____________________ ___________________________
Name of individual Relationship to patient Primary phone #

Name of individuals to whom all of your information may be disclosed to:

____________________________ ____________________ ___________________________
Name of individual Relationship to patient Primary phone #

____________________________ ____________________ ___________________________
Name of individual Relationship to patient Primary phone #

If patient is a minor, please provide name of parents/guardians who is the responsible party:

____________________________ ____________________ ___________________________
Name of individual Relationship to patient Primary phone #

____________________________ ____________________ ___________________________
Name of individual Relationship to patient Primary phone #

PRIMARY / DENTAL INSURANCE INFORMATION

____
Primary Insurance Company Subscriber ID Group #

____
Subscriber's Last Name Subscriber's First Name Relationship to Patient Date of Birth

____
Secondary Insurance Company Subscriber ID Group #

____
Subscriber's Last Name Subscriber's First Name Relationship to Patient Date of Birth

PRIMARY / MEDICAL INSURANCE INFORMATION

____
Primary Insurance Company Subscriber ID Group #

____
Subscriber's Last Name Subscriber's First Name Relationship to Patient Date of Birth

____
Secondary Insurance Company Subscriber ID Group #

____
Subscriber's Last Name Subscriber's First Name Relationship to Patient Date of Birth

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account?: ____
Address (if different than page 1): ____
Home phone: _____________________________ Cell phone: _____________________________________
Email Address: ________________________________ Social Security #: _________ - _____ - __________

HEALTHCARE PROVIDER INFORMATION

Dentist: ____ Phone #: _________________________
Primary Care Doctor: ____________________________________ Phone #: ________________________
Other Provider(s): ______________________________________ Phone #: _________________________

MEDICAL HISTORY – Now or in the past, have you had

Birth defects or heredity problems	□ Yes	□ No
Bone fractures or major injuries	□ Yes	□ No
Any injuries to the face, head, neck	□ Yes	□ No
Arthritis or joint problems	□ Yes	□ No
Endocrine or thyroid problems	□ Yes	□ No
Diabetes or low sugar	□ Yes	□ No
Kidney problems	□ Yes	□ No
Cancer, tumor, radiation treatment, or chemotherapy	□ Yes	□ No
Stomach ulcer, hyperacidity, acid reflux	□ Yes	□ No
Immune system problems	□ Yes	□ No
History of osteoporosis	□ Yes	□ No
Gonorrhea, syphilis, herpes, sexually transmitted diseases	□ Yes	□ No
AIDS or HIV positive	□ Yes	□ No
Hepatitis, jaundice, or other problems	□ Yes	□ No
Polio, mononucleosis, tuberculosis, pneumonia	□ Yes	□ No
Seizures, fainting spells, neurologic problems	□ Yes	□ No

Mental health disturbance or depression	□ Yes	□ No
Vision, hearing, or speech problems	□ Yes	□ No
History of eating disorder (anorexia, bulimia, etc.)	□ Yes	□ No
High or low blood pressure	□ Yes	□ No
Excessive bleeding or bruising	□ Yes	□ No
Chest pain, shortness of breath, tires easily, swollen ankles	□ Yes	□ No
Angina, arteriosclerosis, stroke or heart attack	□ Yes	□ No
Skin disorder (other than common acne)	□ Yes	□ No
Do you eat a well-balanced diet	□ Yes	□ No
Frequent headaches or migraines	□ Yes	□ No
Frequent ear infections, colds, throat infections	□ Yes	□ No
Asthma, sinus problems, hay fever	□ Yes	□ No
Tonsil or adenoid condition	□ Yes	□ No

DENTAL HISTORY – Now or in the past, have you had:

Permanent or extra (supernumerary) teeth removed	□ Yes	□ No
Supernumerary (extra) or congenitally missing teeth	□ Yes	□ No
Chipped or injured primary or permanent teeth	□ Yes	□ No
Any sensitive or sore teeth	□ Yes	□ No
Bleeding gums, bad taste, or mouth odor	□ Yes	□ No
Jaw fractures, cysts, infections	□ Yes	□ No
Any teeth treated with root canals or pulpotomies	□ Yes	□ No
"Gum boils" , frequent canker sores or cold sores	□ Yes	□ No
History of speech problems or speech therapy	□ Yes	□ No
Difficulty breathing through your nose	□ Yes	□ No
Food impaction between the teeth	□ Yes	□ No
Mouth breathing habit or snoring at night	□ Yes	□ No
Teeth causing irritation to lip, cheek, or gums	□ Yes	□ No
Abnormal swallowing (tongue thrust)	□ Yes	□ No
Tooth grinding or clenching	□ Yes	□ No
Clicking, locking in jaw joints	□ Yes	□ No
Soreness in jaw or face muscles	□ Yes	□ No
Ringing in ears, difficulty chewing or opening jaw	□ Yes	□ No
Have you ever been treated for "TMJ" or "TMD" problems	□ Yes	□ No
Any broken or missing fillings	□ Yes	□ No
Any trouble associated with previous dental treatment	□ Yes	□ No
Have you ever been diagnosed with gum disease	□ Yes	□ No

ALLERIES – Have you had allergies or reactions to any of the following:

Local anesthetics (Novocain, lidocaine, xylocaine)	□ Yes	□ No
Latex (gloves, balloons)	□ Yes	□ No
Aspirin	□ Yes	□ No
Metals (jewelry, clothing snaps)	□ Yes	□ No
Penicillin	□ Yes	□ No
Other antibiotics: ________________________________	□ Yes	□ No
Ibuprofen (Motrin, Advil)	□ Yes	□ No
Acrylics	□ Yes	□ No
Plant pollens	□ Yes	□ No
Animals	□ Yes	□ No
Foods	□ Yes	□ No
Other: ____	□ Yes	□ No

Please list any medications you are taking: (Prescription or over the counter)

- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________

General Symptoms: Please check all that apply

Do you usually breathe through your mouth?	□ Yes □ No
Do you snore while sleeping?	□ Yes □ No
Do you stop or pause your breathing while sleeping that you know of?	□ Yes □ No
Do you get tired easily or fall asleep during the day?	□ Yes □ No
Do you use sleep medication?	□ Yes □ No
Do you have any facial pain?	□ Yes □ No
Do you have difficulty opening or closing your mouth or while chewing?	□ Yes □ No
Do you gums bleed?	□ Yes □ No
Is your pillow wet in the morning?	□ Yes □ No
Do you keep your mouth open while watching TV or using the computer?	□ Yes □ No
Do you easily catch colds / have allergies?	□ Yes □ No
Do you have difficulty pronouncing sounds?	□ Yes □ No
Do you have a history of the following:	□ Thumb sucking □ Finger sucking □ Tongue sucking □ Nail biting
Do you grind or clench their teeth during the day or night?	□ Yes □ No □ During the day □ Only at night □ Both

What do you hope to achieve from this evaluation? ____
Describe the problem you are experiencing: ____
What do you think caused the problem? ____
What have you tried to fix the problem? ____
How did you hear about our office? ____
What concerns you about your teeth? ____
Who suggested that you might need orthodontic treatment? ______ ______________________________
Have you had any previous orthodontic treatment? ______ ______________________________________
Do any of your work or leisure activities affect your teeth or jaws? ________________________________
Do you take antibiotic or pre-medication before any dental procedure? ___________________________
Do you, or have they ever had a substance abuse problem? ____________________________________
Do you chew or smoke tobacco? ____
How often do you brush your teeth each day? _________ How often do you floss? _________________
Women: Are you pregnant? _______________Are you trying to become pregnant? _________________

RELEASE AND WAIVER

I authorize release of any information regarding my treatment to our dental and/or medical insurance company. I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify Dr. Smith and his staff of any changes in my medical or dental health.

____ ___________________________

Signature of Responsible Party Date

INFORMED CONSENT

for the Orthodontic Patient
Risks and Limitations of Orthodontic Treatment

• Successful orthodontic treatment is a partnership between the orthodontist and the patient. Dr. Smith and his staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

• Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

• General Health Problems

General health problems, such as bone, blood, or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

• Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with health after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, carefully consider the possibility of a compromised orthodontic result.

• Acknowledgement

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented. I understand that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with Dr. Douglas Smith and have been given the opportunity to ask any questions. I have been asked to make a choice about my child's treatment. By signing below, I hereby consent to the treatment proposed, including radiologic services and authorize Dr. Smith and his staff to provide this treatment. I also authorize Dr. Smith and his staff to provide my child's health care information to his/her other health care providers. I understand that once released, Dr. Smith and his staff have no responsibility for any further release by the individual(s) receiving this information. I hereby consent to the making of diagnostic records, including pre-treatment and post treatment photos, x-rays before, during, and following orthodontic treatment. I understand that my child's treatment fee covers only treatment provided by the orthodontist and that treatment provided by other dental or medical professionals is not included in the fee for my child's orthodontic treatment.

______________________________	______________________________	_______________	__________
Print Name	Signature	Date	Witness