# ADULT

DATE_____

## Let's Get Acquainted

*Welcome! So that we may provide you with the best possible care, please complete **both sides** of this form. All information is completely confidential.*

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

_____

HAVE YOU EVER HAD AN ORTHODONTIC CONSULTATION? YES ☐ NO ☐ OR TREATMENT? YES ☐ NO ☐

PATIENT NAME_____ M / F

NICKNAME_____ AGE _____ BIRTHDATE_____

SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SPOUSE DECEASED ☐

ADDRESS _____

CITY _____ ZIP_____ EMAIL_____
(for appointment confirmation)

HOME/CELL # _____ CELL PROVIDER_____

OCCUPATION_____

EMPLOYER_____

DAYTIME PHONE # _____ EXT._____

SPOUSE _____

OCCUPATION_____ EMPLOYER_____

DAYTIME PHONE # _____ EXT._____

MINOR CHILDREN? NAME/AGE _____

HAVE ANY OTHER FAMILY MEMBERS BEEN SEEN IN OUR OFFICE? YES ☐ NO ☐

IF SO, NAME/RELATIONSHIP _____

REFERRED TO US BY _____

DENTIST _____

TELEPHONE # _____ Last Cleaning Date: M/Y_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT _____

ADDRESS IF DIFFERENT FROM ABOVE _____

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY_____

PHONE # _____

INSURED'S NAME_____ INSURED'S DATE OF BIRTH ____/____/____

POLICY #/ SOCIAL SECURITY # _____

**(SEE BACK SIDE)**

## MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No

   If yes, for what? _____

   Physician's Name _____ Phone _____

2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No

   If yes, please list name and dosage _____
4. Are you allergic to any medication or substance? ..... Yes No

   If yes, please list _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | Yes | No | Ulcers | Yes | No | Hepatitis A (infectious) B (serum) | Yes | No |
| Chest Pain | Yes | No | Diabetes | Yes | No | Venereal Disease | Yes | No |
| Congenital Heart Disease | Yes | No | Thyroid Problems | Yes | No | A.I.D.S. | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | H.I.V. Positive | Yes | No |
| High Blood Pressure | Yes | No | Contact lenses | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Blood Transfusion | Yes | No |
| Artificial Heart Valve | Yes | No | Chronic Cough | Yes | No | Hemophilia | Yes | No |
| Heart Pacemaker | Yes | No | Tuberculosis | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Asthma | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Hay Fever | Yes | No | Liver Disease | Yes | No |
| Cortisone Medicine | Yes | No | Latex Sensitivity | Yes | No | Yellow Jaundice | Yes | No |
| Swollen Ankles | Yes | No | Allergies or Hives | Yes | No | Neurological Disorders | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Epilepsy or Seizures | Yes | No |
| Diet (Special/Restricted) | Yes | No | Radiation Therapy | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Chemotherapy | Yes | No | Nervous/Anxious | Yes | No |
| Kidney Trouble | Yes | No | Tumors | Yes | No | Psychiatric/Psychological Care | Yes | No |

7. Do you premedicate with antibiotics for dental procedures? ..... Yes No
8. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

   If yes, please list _____
9. **Women.** Are you: Pregnant? Yes, _____Months No Nursing? Yes No Taking birth control pills? Yes No

Are you experiencing:

| | | | | | |
|---|---|---|---|---|---|
| Clicking or popping of the jaw | Yes | No | Difficulty in chewing | Yes | No |
| Pain (Joint, ear, side of face) | Yes | No | Headaches, neckaches | Yes | No |
| Difficulty in opening or closing of the mouth | Yes | No | Sore Muscles (neck, face) | Yes | No |

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.*

Signature _____ Date _____

HISTORY REVIEW