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ADULT MEDICAL & DENTAL HISTORY

A B C

DATE _____

PATIENT S NAME _____ (first / mi. / last / nickname)

ADDRESS _____ (street / city / zip) How long? _____

Previous address (if less than 3 years) _____ (street / city / zip)

EMAIL ADDRESS _____

PHONE: Home _____ Work _____

DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL STATUS _____

OCCUPATION _____ SSN _____ / _____ / _____

EMPLOYER _____ How long? _____

EMPLOYER ADDRESS _____

Is orthodontic insurance a benefit of this company? _____ Group Number _____

Insurance Company _____

Address _____

Phone # _____

NAME OF SPOUSE _____ DATE OF BIRTH _____ AGE _____

SPOUSE S OCCUPATION _____ SSN _____ / _____ / _____

EMPLOYER _____ How long? _____

EMPLOYER ADDRESS _____

Is orthodontic insurance a benefit of this company? _____ Group Number _____

Insurance Company _____

Address _____

Phone# _____

Please sign both areas for insurance billing.

I have reviewed the following treatment plan, I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____ (SIGNED (PATIENT, OR PARENT IF MINOR)) _____ (DATE)

I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

_____ (SIGNED (INSURED PERSON)) _____ (DATE)

PHYSICIAN S NAME _____ ADDRESS _____ PHONE _____

DENTIST S NAME _____ ADDRESS _____ PHONE _____

NAME OF NEAREST RELATIVE (not living with you)

_____ (street / city / zip / phone)

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO.

Y	N		Y	N		Y	N	
☐	☐	AIDS - HIV	☐	☐	Convulsions/Seizures	☐	☐	Hepatitis or Liver Disease
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Ear Stuffiness, Itching or Noises	☐	☐	Leukemia
☐	☐	Blood Transfusions	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency
☐	☐	Birth Defects	☐	☐	Eye Problem	☐	☐	Oral Ulcers
☐	☐	Bone or Joint Problems	☐	☐	Excessive Bleeding Problem	☐	☐	Orthopedic Problems
☐	☐	Bruising Easily	☐	☐	Excessive Gagging	☐	☐	Rheumatic Fever
☐	☐	Cancer or Malignancies	☐	☐	Fainting or Dizziness	☐	☐	Scoliosis
☐	☐	Cerebral Palsy	☐	☐	Growth & Development Problems	☐	☐	Syndrome _____
☐	☐	Chronic Adenoid/Tonsil Infection	☐	☐	Headaches	☐	☐	Tuberculosis
☐	☐	Chronic Ear Infections	☐	☐	Hearing/Speech Problems	☐	☐	Other _____
☐	☐	Cleft Lip/Palate	☐	☐	Heart Murmur			
☐	☐	Congenital Heart Disease	☐	☐	Hemophilia			

	Yes	No
Are you currently taking any medication?	☐	☐
What? _____		
Are you allergic to any food or medicine?	☐	☐
What? _____		
Have you ever had orthodontic treatment?	☐	☐
Have you ever had periodontal disease?	☐	☐
Have you ever been treated for a bad bite ?	☐	☐
Have you ever been treated for problems or discomfort with your jaw joint or facial muscles?	☐	☐
Do you ever awaken with soreness of your teeth or jaws?	☐	☐
Do you clench or grind your teeth during the day?	☐	☐
Have you ever been told that you grind your teeth while sleeping?	☐	☐
Are your teeth sensitive when chewing?	☐	☐
Do you have tension or migraine headaches?	☐	☐
Do you frequently have neckaches or stiff neck muscles?	☐	☐
Do your jaw muscles become tired frequently?	☐	☐
Do you have difficulty in opening your mouth widely?	☐	☐
Do you have difficulty in swallowing?	☐	☐
Have you ever had arthritis?	☐	☐
Have you ever received a severe blow to the side of the head or jaw?	☐	☐
Have you ever had problems with your ears, such as ringing or change of hearing?	☐	☐
Do you ever hear clicking or popping sounds from your jaw joint?	☐	☐
Are you presently in any pain from your jaw joint or muscles?	☐	☐
Does pain or discomfort from your jaw joint interfere with your work or other activities?	☐	☐
Are there times when you notice that this problem or pain is less or gone completely?	☐	☐
Do you feel you need treatment for this problem?	☐	☐
Do you have a problem with insomnia?	☐	☐
Do you take aspirin frequently?	☐	☐
Is there any other information you feel we should know?	☐	☐

What is your chief concern?

Please explain. _____

_____

REFERRED TO THIS OFFICE BY: _____

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE _____ DATE _____