ORTHODONTIQUE

THE STYLE OF THE SMILE

ADULT PATIENT HISTORY

Patient Information:

Date:_____

Patient's Last Name _____ First_____ Initial_____

Home Address:_____ City, State, Zip code:_____

Home Phone (_____)_____ Cell Phone (_____)_____

□ Single □Married □Separated □ Divorced Birth Date _____/_____/_____ Sex: □Male □Female

SS#_____-_____-_____ E-mail address(s)_____

Employer:_____

Job Title:_____ Phone# (_____)_____ Ext_____

Spouse Information:

Spouse's Full Name:_____ Title □Mr. □Dr. □Other_____

Occupation_____ E-mail Address_____

Address (if different) _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Responsible Party:

Name _____

Address (if different):_____ City, State, Zip code:_____

Home Phone (if different): (_____)_____ Cell Phone (_____)_____

Who is responsible for bringing patient to orthodontic appointments?_____

General Information:

Whom may we thank for referring you?_____

Childs Name_____ _____ age _____ had orthodontic treatment? □YES □NO

Childs Name_____ age _____ had orthodontic treatment? □YES □NO

Childs Name_____ _____ age _____ had orthodontic treatment? □YES □NO

Childs Name_____ _____ age _____ had orthodontic treatment? □YES □NO

If yes, where were they treated?_____

Emergency Information: Outside of immediate Family/Household

Name _____ Phone (_____)_____

Address:_____ City, State, Zip code:_____

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Insurance Information:

Primary Orthodontic Insurance	**Secondary Orthodontic Insurance**
Do you have Orthodontic Coverage? □YES □NO	**Do you have Orthodontic Coverage? □YES □NO**
Insurance Co. Name: _____	Insurance Co. Name: _____
Insurance Co. Address:_____	Insurance Co. Address:_____
Insurance Co. Phone Number:_____	Insurance Co. Phone Number:_____
Group# (Plan, Local or Policy#):_____	Group# (Plan, Local or Policy#):_____
Insured's Name:_____	Insured's Name:_____
Relationship to Patient:_____	Relationship to Patient:_____
Insured's Birth Date: _____/_____/_____	Insured's Birth Date: _____/_____/_____
Insured's ID#(SS#)_____	Insured's ID#(SS#)_____
Insured's Employer:_____	Insured's Employer:_____

Dentist:

Patient's Dentist: _____ Phone (_____)_____

Address:_____ City, State, Zip code:_____

Last Seen _____ Reason _____

When your last cleaning? _____

Other dentists/ dental Specialists now being seen:_____

Reason_____

Dental History:

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

_____

Have you ever been evaluated for orthodontic treatment? □YES □NO

Now or in the past, have you had:

Jaw fractures, cyst, infections?	□YES □NO
History of speech problems or speech therapy?	□YES □NO
History of speech problems?	□YES □NO
Frequent oral habits (sucking finger, chewing pen, etc)	□YES □NO
Teeth causing irritation to lip, cheek, or gums?	□YES □NO
Have you ever been treated for "TMJ" or "TMD"	□YES □NO
Any serious trouble associated with previous treatment	□YES □NO
Have you ever been diagnosed with gum disease or pyorrhea	□YES □NO

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Medical History:

Are you under a physician's care now? □YES □NO

Have you ever been hospitalized or had an operation? □YES □NO

Have you ever had a serious injury to his/her head or neck? □YES □NO

Are you taking any medication, pills, or drugs? (Include illegal/recreational drugs) □YES □NO

Please explain if you have answered YES to any of the above questions. _____

_____

Are you allergic to any medications or substances? (Please check box for allergic reaction below) □YES □NO

□Aspirin □Penicillin □Acrylic □Metal □Latex Rubber □Local Anesthetics □Foods_____

□Other _____

Medication _____ Taken for _____

Do you have or have you ever had any of the following:

Heart Trouble/Disease	□YES □NO	Leukemia	□YES □NO	Frequent Diarrhea	□YES □NO
Heart Murmur	□YES □NO	Recent Blood Transfusion	□YES □NO	Excessive Thirst	□YES □NO
Irregular Heart Beat	□YES □NO	Swelling of Limbs	□YES □NO	Hypoglycemia	□YES □NO
Angina/Chest Pain	□YES □NO	Lung Disease	□YES □NO	Stroke	□YES □NO
Congenital Heart Disorder	□YES □NO	Breathing Problems	□YES □NO	Hepatitis, Jaundice or Liver Disease	□YES □NO
Mitral Valve Prolapse	□YES □NO	Shortness of Breath	□YES □NO	Kidney Problems	□YES □NO
Scarlet Fever	□YES □NO	Frequent Cough	□YES □NO	Renal Dialysis	□YES □NO
Rheumatic Fever	□YES □NO	Hay Fever	□YES □NO	Parathyroid Disease	□YES □NO
Artificial Heart Valve	□YES □NO	Sinus Trouble	□YES □NO	Arthritis/Gout	□YES □NO
Heart Pace Maker	□YES □NO	Asthma	□YES □NO	Rheumatism	□YES □NO
Heart Surgery	□YES □NO	Fever Blisters	□YES □NO	Pain in Jaw Joints	□YES □NO
High Blood Pressure	□YES □NO	ADD/DHD	□YES □NO	Cortisone Medicine	□YES □NO
Low Blood Pressure	□YES □NO	Emphysema	□YES □NO	Artificial Joints	□YES □NO
Blood Disease	□YES □NO	Tuberculosis	□YES □NO	AIDS/ HIV Positive	□YES □NO
Alcohol Use/Abuse	□YES □NO	Cancer	□YES □NO	Herpes (Cold Sore)	□YES □NO
Depression	□YES □NO	Radiation Therapy	□YES □NO	Sexually Transmitted Disease	□YES □NO
Bruise Easily	□YES □NO	Chemotherapy	□YES □NO	Drug Addiction/Use	□YES □NO
Anemia	□YES □NO	Stomach/Intestinal Disease	□YES □NO	Snoring/Sleep Apnea	□YES □NO
Excessive Bleeding	□YES □NO	Ulcers	□YES □NO	Vision or Hearing Problem	□YES □NO
Sickle Cell Disease	□YES □NO	Recent Weight Loss	□YES □NO		
Hemophilia	□YES □NO				

Have you ever had any other serious illness not checked above? Describe:_____

_____

Have you ever taken IV or Oral bisphosphonates for bone disorder? □YES □NO

To the best of your knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail I will inform the doctor promptly of any medications legal or illegal, prescription or non-prescription that I am taking. In Accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a NOTICE that describes how medical information about you may be used and disclosed and how you can get access to this information is available upon request. Should I desire to have a copy of this NOTICE, I will check the following box and notify the RECEPTIOINST: □ I DO WANT A COPY OF 'NOTICE' □ I DO NOT WANT A COPY OF 'NOTICE'

Signature: _____ Date:_____

Reviewed by Doctor:_____ Date: _____

History review and significant findings:_____

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Medical History Update

Date	Comments	Signature