Str8rsmiles

Patient Health History Form

Today's Date: ___________

Name:____
Last First MI

Gender: ☐ Male ☐ Female Birth date:_____________ Age: _____________

Home Address:____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: ___________________Work Phone: _______________Cell:________________

Driver License Number:______________________

Email Address:____

Employer:________________________Address:_____________________________________

Occupation: ______________________________How long have you worked there?_________

What is the best time to reach you? _________Other family members seen by us?___________

Dentist Name: _______________________☐ Previous ☐ Present Date last visit?___________

Person Responsible for Account: __________________________

Spouse Information

Name: _________________________________ Employer: _____________________________

Primary Phone Number: ___________________Social Security Number: __________________

Birthdate: _____________________ Driver License Number: ___________________________

Relative or friend not living with you:

Name: ___________________________ Relation: ____________________________________

Home Phone: ___________________Work Phone: _________________Cell:_______________

Orthodontic Insurance

Primary: ______________________ Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Company Name: ____

Insurance Company Address:____

Insurance Company Phone Number: ____________________________

Insured Name:________________________ Relation:_____________Insured Birthdate:_____________

Group Number: __________________ Insured ID Number:__________________________________

Insured Employer:___________________________ Employer Address:_____________________

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Secondary Insurance:

Primary: _________________ Orthodontic Coverage? □ Y □ N Dental Coverage? □ Y □ N

Insurance Company Name: ________________________

Insurance Company Address:____

Insurance Company Phone Number: ________________________

Insured Name:____________________ Relation:__________________Insured Birthdate:__________

Group Number: _____________________Insured ID Number:_________________________________

Insured Employer:________________________

Employer Address:____

Payment is due in full at the time of treatment unless prior arrangements have been approved by our office.

If this office accepts insurance, I understand that I am responsible for payment of services and paying any co-payment that my insurance does not cover, including deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature   Date

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Patient Health History Form

Medical History

Do you have a personal physician? Y N Physician's Name:_________________________________
Physician’s Phone Number:____________________ Date of last visit:___________________________
Your current health is Good Fair Poor
Are you currently under the care of a physician? Y N
Please explain:____
Do you smoke or use tobacco in any other form? Y N
Have you had any metal rods, pins, or implants? Y N
Are you taking any prescription/ over the counter drugs? Y N
Please list each one:____
Have you ever taken Fosamax or any bisphosphonate? Y N
Have you ever taken Phen-Fen (Redux or Pondimin)? Y N
If so, when?

WOMEN: Are you taking birth control pills? Y N
Are you pregnant? Y N Week Number:___________ Are you nursing? Y N

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding/ Hemophilia
Y N Aids
Y N Alcohol/ Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/ Joints/ Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/ Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/ Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes/ Fever Blisters
Y N HIgh Blood Pressure
Y N HIV
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/ Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any other serious medical conditions that you have had:___________________________

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/ Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

List any other drug or materials allergies:____

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Our Office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? ☐ Y ☐ N

If Yes, please explain:____

Patient Signature:____

Doctor Signature:____

Dental History

What would you like orthodontics to accomplish?_______________________________________

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious or difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/ TMD)? ☐ Y ☐ N

Your current overall health is: ☐ Good ☐ Fair ☐ Poor

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N If not, what would you change?________________________________

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. This office reserves the right to verify the credit of potential patients and/or patients prior extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

____

Signature Date

Office Use Only

I verbally reviewed the medical/dental information with the patient need herein.

Initials: ____________________

Date: ______________________

Doctor's Comments ____

____

____

Aberdeen	**Edgewood**	**Elkridge**
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