Adult Health History Form
Date:____/_____/_____


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818-236-3636 • www.GotBeautifulSmile.com

## CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ Date of Birth____/_____/_____ Age _____ M / F (Circle)
Last First

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Employer _____ Work Phone _____ Occupation _____

Patient's Dentist _____ Date of last dental exam ____/_____/_____ recent x-rays? Y / N (Circle)

Has patient been placed on an oral hygiene program by a general dentist? ☐No ☐Yes - How often are your visits?_____

Who may we thank for referring you to our office? _____

## CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient:_____
(if different from patient) Last First

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Employer _____ Work Phone _____ Occupation _____

*If Patient is married, please complete the following:*

Spouse's Name _____
Last First

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email: _____

Employer _____ Work Phone _____ Occupation _____

## INSURANCE INFORMATION

Primary Policy Holder's Name_____ SS # or Policy #_____
Last First

Insurance Company _____ Group #_____ Date of Birth of Insured____/_____/_____

Ins. Co. Address_____ Ins. Co. Phone _____

Secondary Policy Holder's Name_____ SS # or Policy #_____
Last First

Insurance Company _____ Group #_____ Date of Birth of Insured____/_____/_____

Ins. Co. Address_____ Ins. Co. Phone _____

*I hereby authorize and direct payment of the dental benefits to Dr. Charles C. Low based on the dictates of my plan. The signature below will represent the signature on file for any insurance billing.*

Signature _____ Date: _____/_____/_____

## DENTAL HISTORY

Reason for Orthodontic Examination_____

Has patient had previous orthodontic treatment/consultation? ☐No ☐Yes explain _____

Check any of the following that apply to patient:

| | | | |
|---|---|---|---|
| ☐Speech Problems | ☐Thumb Sucking | ☐Have Tonsils Removed | ☐Lip Biting |
| ☐Nail/Finger Biting | ☐Bleeding Gums | ☐Grinding Teeth | ☐Food Collection Between Teeth |
| ☐Periodontal Treatment | ☐Mouth Breather | ☐Missing Teeth | ☐Clicking/Popping of Jaw |
| ☐Extra Teeth | ☐Trauma to Teeth/Jaw | ☐Vomit/Gags easily | ☐Apprehension in dental office |

Please explain if any of the above was checked:_____

Any other dental related issues not listed above (explain) _____

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## MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Patient's Height _____ Patient's Weight _____ Date of last medical exam _____/_____/_____

Is patient under care of a physician now? ☐No ☐Yes - explain _____

Has patient been hospitalized? ☐No ☐Yes - explain _____

Has patient ever had surgery? ☐No ☐Yes - explain _____

Does patient have a tendency for? (check all that apply): ☐Colds ☐Sore Throats ☐Ear Infections

Has patient had any history or difficulty with any of the following? Please circle a response to each.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A.I.D.S./H.I.V. | Yes No | Cerebral Palsy | Yes No | Hay Fever | Yes No | Pneumonia | Yes No |
| Anemia | Yes No | Cleft Lip/Palate | Yes No | Hearing Problems | Yes No | Premature Birth | Yes No |
| Abnormal Bleeding | Yes No | Convulsion | Yes No | Heart Problems | Yes No | Psychiatric Treatment | Yes No |
| Bisphosphanate Meds | Yes No | Developmental Disability | Yes No | Hepatitis | Yes No | Rheumatic Fever | Yes No |
| Blood Transfusion | Yes No | Diabetes | Yes No | Jaundice | Yes No | Sinus Problems | Yes No |
| Bone Disorder | Yes No | Endocrine Problems | Yes No | Kidney Disease | Yes No | Smoking/Tobacco Use | Yes No |
| Bruise/Bleed Easily | Yes No | Epilepsy | Yes No | Liver Disease | Yes No | Thyroid Disease | Yes No |
| Cancer | Yes No | Fainting or Dizziness | Yes No | Nervous Disorders | Yes No | Tuberculosis | Yes No |

Other (please explain) _____

If any of the above was circled "Yes", please explain dates of occurrence and any additional information: _____

_____

Any broken bones? ☐No ☐Yes If yes, please list _____ Healed satisfactorily? ☐Yes ☐No

Has patient ever had an asthmatic attack? ☐No ☐Yes If yes, Mild Moderate Severe When and how often? _____

Is patient on any medication(s)? ☐No ☐Yes List names and purpose: _____

_____

Is patient allergic to, or ever had an adverse reacton to the following? If yes - Please circle ALL that apply:

| | | | | | | |
|---|---|---|---|---|---|---|
| Aspirin | Barbiturates | Sedatives | Penicillin | Local anesthetics | Amoxicillin | Sleeping pills |
| Sulfa drugs | Cosmetic Jewelry | Latex | Nickel | None Known | Others: _____ | |

Musical instrument(s) played with mouth or lips _____ Sport(s) played with mouth guard _____

*I understand that the information that I have given is correct, that it will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need.*

Signature _____ Date _____

**********FOR OFFICE USE ONLY**********

Dental and Medical History reviewed by _____ (initial of Doctor)

Additional Notes: _____

_____