

WELCOME TO DR. PATEL'S Orthodontic Office

Adult's Health History

Today's Date _____
Mr. Mrs. Ms. Dr.
Name:(L) _____ (F) _____
I prefer to be called: _____ M F
Birth date ___/___/___ Age _____ SS# _____
Home Address: _____

City _____ Zip _____
[]Single []Married []Divorced []Widowed []Separated
Home# (____) _____ Cell#(____) _____
Wk# (____) _____ Ext: _____ DL# _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
How Long there? _____ Occupation: _____
Where & When are best times to reach you? _____
Whom may we Thank for referring you? _____
Other Family members see by us: _____
Previous / Present Dentist: _____

Spouse Information

His / Her Name: _____
Employer: _____ Occupation: _____
Wk#:(____) _____ Ext: _____ Cell#:(____) _____
Birth date: ___/___/___ Age: _____ SS#: _____
Relative or Friend not living with you.
Name: _____ Relation: _____
Wk#:(____) _____ Ext: _____ Home#:(____) _____

Authorization

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If Dr. Patel's office accepts the insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorized the use of this signature on all my insurance submissions. Whether manual or electronic.

Signature _____ Date _____

Insurance

Orthodontic Coverage? [] Yes [] No

Primary

Insurance Co. Name: _____
Insurance Address: _____
City _____ State _____ Zip _____
Insurance Phone:(____) _____
Group#(Plan, Local, or Policy#): _____
Insured's Name: _____ Relation: _____
Insured's DOB: ___/___/___ Insured's SS#: _____
Insured's Employer: _____
Insured's Employer's Address: _____
City _____ State _____ Zip _____

Orthodontic Coverage? [] Yes [] No

Secondary

Insurance Co. Name: _____
Insurance Address: _____
City: _____ State _____ Zip _____
Insurance Phone:(____) _____
Group#(Plan, Local, or Policy#): _____
Insured's Name: _____ Relation: _____
Insured's DOB: ___/___/___ Insured's SS#: _____
Insured's Employer: _____
Insured's Employer's Address: _____
City _____ State _____ Zip _____

Medical History

Do you have a Personal Physician? Y N
 Physician's Name _____
 Phone #: _____ Date of last visit _____

Your current physical 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 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: _____
 Have you ever taken Phen-fen? Y N
 If so, When? _____

For Women: Are you taking birth control pills? Y N
 Are you pregnant? Y N Weeks #: _____
 Are you nursing? Y N

Have you ever had and of the following diseases or medical problems

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

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

- | | |
|------------------------|------------------|
| Y N Aspirin | Y N Latex |
| Y N Codeine | Y N Penicillin |
| Y N Dental Anesthetics | Y N Tetracycline |
| Y N Erythromycin | Y N Other |
| Y N Jewelry / Metal | |

Please list any other drugs / materials that you are allergic to:

Dental History

What are the main concerns that you would like orthodontics to accomplish:

Have you ever had or been evaluated for Orthodontic treatment? Y N
 Have you ever had a serious/difficult problem associated with any previous dental work? Y N
 Do you now or have you ever experienced pain / discomfort in your jaw joint (TMD/TMJ) Y N
 Your current dental health is:
 Good Fair Poor
 Do you still have wisdom teeth? Y N
 Have you ever had an injury to your:
 Mouth Teeth Chin Y N
 Do you have any speech problems?

Do you generally breathe through your mouth?
 While Awake? Y N
 While Asleep? Y N
 Do you have any missing or extra permanent teeth? Y N
 Are you happy with the way your smile looks? 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 that 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 status of potential patients and/ or parents of patients prior to 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 - OFFICE USE ONLY

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

Initials: _____ Date: _____
 Doctor's Comments: _____

