WELCOME TO Bright Star Orthodontics

Adult's Health History

Today's Date_____

Mr. Mrs. Ms. Dr.

Name:(Last)_____(First)_____

I prefer to be called:_____ M F

Birth date_____/____/____ Age_____

SS#_____-_____-_____

Home Address:

_____

City_____ Zip_____

Cell #1 (_____)_____

Cell #2 (_____)_____

Employer:_____

Occupation:_____

Whom may we Thank for referring you?

_____

Other Family members see by us:_____

Previous / Present Dentist:_____

Spouse Information

His / Her Name:_____

Birth date_____/____/____ Age_____

Cell #:(_____)_____

SS#_____-_____-_ _____

Employer:_____

Occupation:_____

Primary Dental Insurance

Orthodontic Coverage? YES [ ] NO [ ]

Insurance Co. Name:_____

Insurance Address:_____

City_____State_____Zip_____

Insurance Phone:(_____)_____

Insurance ID #:_____

Group #:_____

Insured's Name:_____

Relation to patient:_____

Insured's DOB:_____/_____/_____

Insured's SS#:_____-_____-_____

Insured's Employer:_____

Secondary Dental Insurance (if you have two insurances)

Orthodontic Coverage? YES [ ] NO [ ]

Insurance Co. Name:_____

Insurance Address:_____

City:_____State_____Zip_____

Insurance Phone:(_____)_____

Insurance ID #:_____

Group#:_____

Insured's Name:_____

Relation to patient:_____

Insured's DOB:_____/_____/_____

Insured's SS#:_____-_____-_____

Insured's Employer:_____

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 Bright Star Orthodontics PA 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_____

Medical History

Are you currently under the care of a physician? Y N
Physician's Name_____
Phone #:_____ Date of last visit_____

Your current physical health is: Good [ ] Fair [ ] Poor [ ]

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
If so, please list:
_____

For Women:
Are you taking birth control pills? Y N
Are you pregnant? Y N
If so, how many weeks?_____

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

Abnormal Bleeding	Y N	Sickle Cell Disease/Traits	Y N
AIDS	Y N	Herpes/Fever Blisters	Y N
Alcohol/Drug Abuse	Y N	High Blood Pressure	Y N
Anemia	Y N	Cancer/Chemotherapy	Y N
Arthritis	Y N	Hospitalized for Any Reason	Y N
Artificial Valves	Y N	Artificial Bones/Joints	Y N
Asthma	Y N	Rheumatic/Scarlet Fever	Y N
Blood Transfusion	Y N	Liver Disease	Y N
HIV	Y N	Low Blood Pressure	Y N
Hepatitis	Y N	Mitral Valve Prolapse	Y N
Psychiatric Problems	Y N	Pacemaker	Y N
Congenital Heart Defect	Y N	Colitis	Y N
Diabetes	Y N	Radiation Treatment	Y N
Difficulty Breathing	Y N	Venereal Disease	Y N
Emphysema	Y N	Seizures	Y N
Epilepsy	Y N	Shingles	Y N
Hemophilia	Y N	Kidney Problems	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		

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

_____

Are you allergic to any of the following?

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

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 had pain or 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 a 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 teeth? Y N

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 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:_____
_____
_____