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#:(____)________

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_________

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_________

Medical History

Do you have a Personal Physican? 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 physican? Y N
Please explain:__________________________________
Do you smoke or use tabacco 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 AIDS
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial 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 Hemophilia
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 Mitral Valve Prooapse
Y N Pacemaker
Y N Psychiatric Provlems
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 Veneral Disease

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

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

Dental History

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

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 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 permanet 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 hae 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 toverify 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:______________________
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