WELCOME!

ADULT HEALTH HISTORY

TODAY'S DATE: ______________________

ABOUT YOU

Name: ______________________

I prefer to be called: ______________________

☐ Male ☐ Female

Birthdate: ______________________

Email Address: ______________________

Home Address: ______________________

How long have you lived at this address? ______________________

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

Home #: ____________ Cell #: ____________

Work #: ______________________

Employer: ______________________

Employer's Address: ______________________

Length of Employment: ________ Occupation: ____________

When/where are the best times to reach you? ______________________

Whom may we thank for referring you? ______________________

____

Other family members seen by Dr. Sadowski? ______________________

General Dentist: ______________________

Last Visit: ______________________

SPOUSE INFORMATION

Name: ______________________

Employer: ______________________

Work #: ____________ Cell #: ____________

Email: ______________________

RESPONSIBLE PARTY

Person Responsible for Account: ______________________

Work #: ____________ Home #: ____________

Billing Address: ______________________

Relationship: ______________________

Employer: ______________________

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No Last Visit: ________

Physician's Name: ____________ Phone #: ____________

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

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explian: ______________________

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: ______________________

Do you smoke or use tobacco of any form? ☐ Yes ☐ No

For Woman: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week#: ________

Are you nursing? ☐ Yes ☐ No

Have you ever had/experienced any of the following?

☐ Abnormal Bleeding
☐ AIDS/HIV+
☐ Anemia
☐ Arthritis
☐ Artificial bones/joints/valves
☐ Asthma
☐ Blood Transfusion
☐ Cancer/Chemotherapy
☐ Congenital Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Drug/Alcohol Abuse
☐ Emphysema
☐ Epilepsy/Fainting
☐ Fever Blisters/Herpes
☐ Glaucoma
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery/Pacemaker
☐ Hemophilia
☐ Hepatitis
☐ High/Low Blood Pressure
☐ Hospitalization
☐ Kidney Problems
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Rheumatic Fever
☐ Severe Headaches
☐ Shingles
☐ Sinus Problems
☐ Stroke
☐ Tuberculosis
☐ Ulcers/Colitis
☐ Venereal Disease

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

____

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

____

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

DENTAL HISTORY

Do you like your smile? ☐ **Yes** ☐ **No**

What are the main concerns that you would like orthodontics to address? ____________________

Have you ever been evaluated for orthodontic treatment? ☐ Yes ☐ No By whom? ____________ When? ____________

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

Do you require antibiotics before dental work? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

How many times daily do you brush? ____________

Do you floss your teeth daily? ☐ Yes ☐ No

Is your water fluoridated? ☐ Yes ☐ No

Are you taking fluoridated supplements? ☐ Yes ☐ No

Do you have any of the following habits?

☐ Lip Sucking/Biting ☐ Nail Biting ☐ Thumb/Finger Sucking ☐ Tongue Thrust ☐ Clench/Grind Teeth

Do you generally breath through your mouth? ☐ Yes ☐ No If yes: ☐ While Awake ☐ While Asleep

Have your adenoids or tonsils been removed? ☐ Yes ☐ No

Do you have any missing/extra permanent teeth? ____________

Do you have any speech problems? ____________

Do your gums bleed? ☐ Yes ☐ No

Do you still have any wisdom teeth? ☐ Yes ☐ No

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

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we chould contact?

Name: ____________ Relationship: ____________

Home #: ____________ Work #: ____________

ADDITIONAL INFORMATION

Any additional information you can give us would be appreciated as the more we know about each other, the better we can help manage your treatment both at home and in the office.

____

____

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Thank you for filling out this form completely.

I affirm that the information I have given 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 the necessary dental services that I may need.

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.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature: ____________________ Date: ____________