WELCOME!

ADULT HEALTH HISTORY

TODAY'S DATE: _____

ABOUT YOU

Name: _____

I prefer to be called: _____

☐ Male ☐ Female Birthdate: _____

Social Security #: _____

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: _____

INSURANCE INFORMATION

Primary Insurance: Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Phone #: _____ Insured's Birthdate: _____

Insured's Social Security #: _____

Group (Plan/Id/Policy) #: _____

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.

_____

_____

_____

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: _____

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