Sexson ORTHODONTICS, LTD. 1-866-5-DR-GARY

Dental/Medical Health History Form for Adult Patients

Patient

Date _____

Patient's last name _____ First name _____Middle initial_____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____
Birth date _____ Sex ___ Male ___Female Social Security #_____
Marital Status ___ Single ___Married ___Separated ___Divorced ___Widowed

Home address _____ City, State, Zip code _____
Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Cell carrier_____

Work phone ( ) _____-_____ Email Address(es) _____
Employer _____ Occupation _____

Closest Relative / Emergency Contact

Spouse, contact or relatives name(s) _____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____
Address (if different than patient address) _____
Home Phone (If different) ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Dentist

Dentist _____ Address, City, State_____
Last seen _____ Reason _____ Next appointment _____
Other dentists/dental specialists now being seen: Name _____ City, State _____
Reason_____

Physician

Physician _____ Address, City, State_____
Last seen _____ Reason _____ Next appointment _____
Most recent physical exam _____ Other physicians/health care providers being seen now:
Name_____ Address, City, State_____
Reason _____
Name_____ Address, City, State_____
Reason _____

General Information

What concerns you about your teeth and what would you like orthodontics to accomplish?

_____
Who referred you or suggested that you might need orthodontic treatment? _____
Why did you select our office? _____
Have you had any previous orthodontic treatment? Please describe._____
Have any other family members been treated in this office? Please name them. _____
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain._____

Financial Responsibility

Who is financially responsible for this account? _____
Address (if different than page 1) _____ City, State, Zip _____
Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Email address(es) _____
Social Security #_____Driver's License #_____

Dental Insurance

Primary policy holder's full name _____ Birth date _____
Social Security #_____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address_____
Insurance company_____ Group # _____ ID#_____
Does this policy have orthodontic benefits? ___ Yes ___No ___ Don't Know

Secondary policy holder's full name _____ Birth date _____
Social Security #_____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address_____
Insurance company_____ Group # _____ ID#_____
Does this policy have orthodontic benefits? ___Yes ___ No ___ Don't Know

Medical Insurance

Policy holder's full name

_____

Insurance Company

_____

Medical History-Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

Now or in the past, have you had:

Yes No DK/U

☐ ☐ ☐ Birth defects or hereditary problems?

☐ ☐ ☐ Bone fractures or major injuries?

☐ ☐ ☐ Any injuries to face, head, neck?

☐ ☐ ☐ Arthritis or joint problems?

☐ ☐ ☐ Endocrine or thyroid problems?

☐ ☐ ☐ Diabetes or low sugar?

☐ ☐ ☐ Kidney problems?

☐ ☐ ☐ Cancer, tumor, radiation or chemotherapy?

☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?

☐ ☐ ☐ Immune system problems?

☐ ☐ ☐ History of osteoporosis?

☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?

☐ ☐ ☐ AIDS or HIV positive?

☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?

☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?

☐ ☐ ☐ Seizures, fainting spells, neurologic problems?

☐ ☐ ☐ Mental health disturbance or depression?

☐ ☐ ☐ Vision, hearing, or speech problems?

☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?

☐ ☐ ☐ High or low blood pressure?

☐ ☐ ☐ Excessive bleeding or bruising, anemia?

☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?

☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?

☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?

☐ ☐ ☐ Skin disorder (other than common acne)?

☐ ☐ ☐ Do you eat a well-balanced diet?

☐ ☐ ☐ Frequent headaches or migraines?

☐ ☐ ☐ Frequent ear infections, colds, throat infections?

☐ ☐ ☐ Asthma, sinus problems, hayfever?

☐ ☐ ☐ Tonsil or adenoid condition?

☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)

☐ ☐ ☐ Latex (gloves, balloons)

☐ ☐ ☐ Metals (jewelry, clothing snaps)

☐ ☐ ☐ Penicillin or other antibiotics

☐ ☐ ☐ Aspirin or ibuprofen (Motrin, Advil)

☐ ☐ ☐ Acrylics

☐ ☐ ☐ Plant pollens

☐ ☐ ☐ Animals

☐ ☐ ☐ Foods

☐ ☐ ☐ Other substances:_____

Dental History

Now or in the past, have you had:

☐ ☐ ☐ Permanent / extra teeth removed?

☐ ☐ ☐ Supernumerary or congenitally missing teeth?

☐ ☐ ☐ Chipped or injured primary or permanent teeth?

☐ ☐ ☐ Any sensitive or sore teeth?

☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?

☐ ☐ ☐ Jaw fractures, cysts, infections?

☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?

☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?

☐ ☐ ☐ History of speech problems or speech therapy?

☐ ☐ ☐ Difficulty breathing through nose?

☐ ☐ ☐ Food impaction between the teeth?

☐ ☐ ☐ Mouth breathing habit or snoring at night?

☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen)

☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?

☐ ☐ ☐ Abnormal swallowing (tongue thrust)?

☐ ☐ ☐ Tooth grinding or clenching?

☐ ☐ ☐ Clicking, locking in jaw joints?

☐ ☐ ☐ Soreness in jaw muscles or face muscles?

☐ ☐ ☐ Ringing in ears, difficulty chewing or opening jaw?

☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" ?

☐ ☐ ☐ Any broken or missing fillings?

☐ ☐ ☐ Any trouble with previous dental treatment?

☐ ☐ ☐ Have you ever been diagnosed with gum disease?

☐ ☐ ☐ Have you ever had an injury to your mouth, teeth, or face? _____

☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment previously?

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that are currently being taken.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe._____
_____

Do you take antibiotic pre-medication before any dental procedures? _____
Do you or have you ever had a substance abuse problem? _____
Do you chew or smoke tobacco? _____
Have you noticed any changes in your face or jaws? _____
List any other physical problems? _____
How often do you brush? _____ How often do you floss? _____
Women: Are you pregnant? ___Yes ___ No Trying to become pregnant? ___ Yes ___ No Taking birth control? ___Yes ___No

Family Medical History

Have your parents or siblings ever had any of the following health problems? If so, please explain._____
Bleeding disorders _____ Diabetes _____
Arthritis _____ Severe allergies _____
Unusual dental problems _____ Jaw size imbalance _____
Other family medical conditions? _____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

Medical History Updates or Changes

Changes_____
Signature _____Date_____
Dental Staff Signature _____ Date_____

Changes _____
Signature _____ Date_____
Dental Staff Signature _____ Date_____

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

_____ _____ _____ _____
Doctor Signature Date Doctor Signature Date

Doctor's Comments_____

_____