Eastside orthodontics

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Adult Health History Form

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Patient Information

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Cell/Home Phone _____ Work # _____

Email _____ SS# _____

Employer _____ Occupation _____

Marital Status : Single _____ Married _____ Divorced _____ Separated _____

Spouse's Name _____ Occupation _____

Referred to Our Office By _____

Dentist _____ Phone _____ Address _____

Have you seen another orthodontist? _____ Name _____

Dental Insurance Information

Primary Insurance Holder Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Email _____

Employer _____ Address _____

Occupation _____ Date of Birth _____ Social Sec # _____

Dental Insurance Co. _____ Group # _____ ID# _____

Insurance Co Address _____ Phone _____

Do you have dual coverage? _____ Yes _____ No If yes:

Secondary Insurance Holder Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Email _____

Employer _____ Address _____

Occupation _____ Date of Birth _____ Social Sec # _____

Dental Insurance Co. _____ Group # _____ ID# _____

Insurance Co Address _____ Phone _____

Emergency Information

Emergency Contact _____

Complete Address _____

Cell Phone _____

Work Phone _____

Relationship to Patient _____

Medical History

General Health ____Poor ____Fair ____Good ____Excellent Do you need to premedicate for dental work? ____Yes ____No

Birth Defects _____

Presently under medical care for _____

Drugs or medication being taken now (Drug and Dosage) _____

Please list any allergies _____

Have you had any surgeries or been hospitalized? _____

PLEASE CHECK YES OR NO TO THE FOLLOWING AND DATE

	Yes	No		Yes	No		Yes	No
ADHD	___	___	Diabetes	___	___	Kidney disorder	___	___
AIDS	___	___	Dizziness	___	___	Liver disorder	___	___
Allergies	___	___	Emotional	___	___	Lung disorder	___	___
Anemia	___	___	Endocrine disorder	___	___	Measles/Mumps	___	___
Arthritis	___	___	Epilepsy	___	___	Neurosis	___	___
Asthma	___	___	Eye disorder	___	___	Nosebleeds	___	___
Autism	___	___	Fainting Spells	___	___	Rheumatic fever	___	___
Blood disorder	___	___	Hearing difficulties	___	___	Scoliosis	___	___
Bone disorder	___	___	Heart disorder	___	___	Seizures	___	___
Breathing difficulties	___	___	Hepatitis	___	___	Speech difficulties	___	___
Bronchitis	___	___	Hospitalized	___	___	Tonsils/Adenoids (removed)	___	___
Cancer	___	___	Hyperactivity	___	___	Tuberculosis	___	___
Cerebral palsy	___	___	Hypertension	___	___	Venereal Disease	___	___
Congenial heart disease	___	___	Injuries	___	___	X-ray treatment	___	___
Convulsions	___	___	Jaundice	___	___			

Other _____

Please give greater details where necessary _____

_____

_____

For Female Patients Only: Are you pregnant or plan to be? _____ Yes _____ No

Dental History

Date of last dental check up _____ Any restorative dental work planned? _____Yes _____No

Injuries or trauma to the face or teeth? _____

Brushing teeth: Several times a day _____ Once a day _____ Nearly every day _____ Rarely _____

Do you play a musical instrument? _____

Oral habits, nail biting, smoking, etc? _____Yes _____No _____ Tongue or Lip Piercing? _____Yes _____No

Breathing: Nose _____ Mouth _____ Difficulty at night _____

Mouth: Usually open _____ Frequently open _____ Seldom open _____

Infections: None _____ Ear _____ Nose _____ Throat _____

Bruxism: Grinds teeth ____Yes ____No at night _____ _____ Do you wear a night guard? ____Yes ____No

Have you had orthodontic treatment before? ____Yes ____No When? _____

Why are you seeking orthodontic treatment? _____