ADULT HEALTH HISTORY FORM

About You

Today's Date _____

Name_____ Preferred Name/Nickname_____

Street Address_____

City_____ State_____ Zip_____ Cell Phone_____

Birth Date_____/_____/_____ Age_____ Sex ❒ M ❒ F Employer_____

Day-Time Phone_____ E-mail Address _____ Spouse's Name_____

How did you hear about our office?_____

What is the reason you are seeking an orthodontic evaluation?_____

Has an orthodontist been consulted previously? ❒ Yes ❒ No Reason: _____

Please list other family members seen in our office and their relation to you: _____

Medical Health Information

Have you been hospitalized for any surgical procedure or serious illness? ❒ Yes ❒No

Name of your physician_____Phone_____

Do you have or have you had any of the following diseases or conditions? (Check those that apply.)

Yes	No		Yes	No		Yes	No	
❒	❒	Diabetes	❒	❒	Fainting Spells, Seizures	❒	❒	AIDS, HIV Positive
❒	❒	Stroke	❒	❒	Scarlet Fever, Rheumatic Heart Disease	❒	❒	Herpes, Fever Blisters
❒	❒	Asthma	❒	❒	Allergies (medicine or other)	❒	❒	Joint Replacement or Implant
❒	❒	Hepatitis	❒	❒	Latex or Nickel Sensitivity/Allergy	❒	❒	Excessive Bleeding or Bruising
❒	❒	Pregnancy	❒	❒	High or Low Blood Pressure	❒	❒	Drug or Alcohol Dependency
❒	❒	Heart Defect, Heart Murmur, Heart Disease				❒	❒	Tonsils/Adenoids Removed

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?____ If so, which drug? _____

Do you have any disease, condition, or problem not listed that you think we should know about? Please explain:

_____

Are you taking any medication at this time? ❒ Yes ❒ No, If yes, please list: _____

Dental Insurance Information

Primary Insurance Company Name_____

Address_____ Group/Plan Number_____

Primary Policy Holder Name_____ Social Security Number ___/____/_____ Date of Birth ___/____/____

Secondary Insurance Company Name_____

Address_____ Group/Plan Number_____

Secondary Policy Holder Name_____ Social Security Number ___/____/_____ Date of Birth ___/____/____

Do you participate in a flex plan? **Y** or **N**

Dental Health Information

Are you experiencing any dental problems? ❒ Yes ❒ No Date of last dental visit ____/____/____

How often do you brush and floss each day? Brush ____ times per day Floss ____ times per day

Dentist_____ Phone_____

Do you have or have you had any of the following diseases or problems?

Yes	No		Yes	No		Yes	No	
❒	❒	Tongue Thrust	❒	❒	Jaw Pain (Joint, Ear, Side of Face)	❒	❒	Finger or Lip Sucking Habit
❒	❒	Sore or Bleeding Gums	❒	❒	Tooth Sensitivity to Heat, Cold or Sweets	❒	❒	Fear of Dental Work
❒	❒	Permanent Tooth Extraction	❒	❒	Previous Orthodontic Treatment	❒	❒	Clenching or Grinding
❒	❒	Difficulty Chewing	❒	❒	Head/Neck, Jaw or Tooth Injury	❒	❒	Missing/Extra Permanent Teeth
❒	❒	Clicking or Popping of the Jaw Joints						

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❒ Accept ❒ Decline

I acknowledge that the above information is correct. I will notify Dr. Fishbein of any changes that occur after this date.

I hereby authorize Dr. Fishbein and his team to perform an initial orthodontic evaluation/examination.

SIGNATURE_____ DATE_____

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