SAKS ORTHODONTICS™

Adult Health History

1. ABOUT YOU

Today's Date:_____

Name:_____
Last First M. Ini.

I prefer to be called:_____ ◯Male ◯Female

Birthdate: _____/_____/_____ Age:_____

SS#:_____

Home Address:_____

_____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Hm#:_____ Cell#_____

Wk#:_____ Ext:_____

Employer:_____

Employer's Address:_____

How long there?_____ Occupation:_____

Where & when are best times to reach you?_____

_____

Whom may we THANK for referring you?_____

Other family members seen by us?_____

2. SPOUSE INFORMATION
(if applicable)

His/Her Name:_____

Employer:_____

Wk#:( ) _____ Ext._____

SS#:_____

Birthdate:_____/_____/_____ Age:_____

Person Responsible for Account:_____

Wk#:( ) _____ Ext._____ Hm#:( )_____

Billing Address:_____

Relation:_____ SS#:_____

Employer:_____

DL#_____

3. ORTHODONTIC INSURANCE

Orthodontic Coverage? ◯Yes ◯No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

Group# (Plan, local, or Policy #):_____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthdate:_____/_____/_____

Insured's SS# / ID# _____

Insured's Employer:_____

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

His/Her Name:_____ Relation:_____

Wk#:_____ Hm#:_____

4. MEDICAL HISTORY

Do you have a personal physician? ◯ Yes ◯ No

Physician's Name:_____

Phone #: ( )_____

Your Current physical health is:

◯Good ◯Fair ◯Poor

Are you currently under the care of a physician?

◯Yes ◯No

Please explain:_____

Are you taking any prescription/over the counter drugs?

◯Yes ◯No

Please list each one:_____

_____

For women:

Are you taking birth control pills? ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No Week #:_____

Are you nursing? ◯ Yes ◯ No

4. MEDICAL HISTORY *continued*

Please CIRCLE if you HAVE or had any of the following diseases or medical problems?

- Anemia/Radiation Treatment
- Artificial Bones/Joints
- Artificial Valves
- Asthma Arthritis
- Blood Transfusion
- Cancer/Chemotherapy
- Congenital Heart Defect
- Diabetes/Tuberculosis
- Difficulty Breathing
- Drug/Alcohol Abuse
- Emphysema/Glaucoma
- Epilepsy/Seizure/Fainting Spells
- Fever Blisters/Herpes
- Heart Attach/Stroke
- Heart Murmur
- Heart Surgery/ Pacemaker
- Hemophilia/Abnormal Bleeding
- Hepatitis
- High/Low Blood Pressure
- HIV +/AIDS
- Hospitalized for Any Reason
- Kidney Problems
- Mitral Valve Prolapse
- Psychiatric Problems
- Rheumatic/Scarlet Fever
- Severe/Frequent Headaches
- Shingles
- Sinus Problems
- Ulcers/Colitis
- Veneral Disease

Please list any other serious medical condition(s) not listed above that you have ever had:_____

_____

Are you allergic to any of the following?

- Aspirin
- Dental Anesthetics
- Penicillin
- Nickel
- Any Plastic
- Latex
- Tetracycline
- Erythromycin
- Other

5. DENTAL HISTORY

General Dentist:_____

Last Visit Date:_____

Is there any dental treatment (fillings, crowns, etc.) that needs to be completed?

_____

What would you like orthodontic treatment to accomplish?

_____

_____

_____

Have you ever been evaluated/had treatment by an orthodontis?

Yes No

Have you ever had a serious/difficult problem associated with any previous dental work?

Yes No

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

Your current DENTAL health is:

Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

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

Do you have any speech problems?

_____

Do you generally breathe through your mouth?

Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?

Yes No

I understand that the information that I have given today 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Thank you for filling out this form completely

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

Doctor's Comments Initials: _____ Date: _____

_____

_____

_____

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

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