WHITE ORTHODONTICS

Date _____

Adult Health History Form

PATIENT INFORMATION

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Birth date _____ Age _____ ❒ Male ❒ Female Marital Status _____

Home address _____ Home phone ( ) _____

City, State, Zip code _____ Mobile phone ( ) _____

How long at this address_____ ❒ Own ❒ Rent Social Security # _____ Work phone ( ) _____

Employer _____ Occupation _____ No. Years Employed_____

Email_____Other family members seen by us? _____

General Dentist _____ Date of last dental visit _____ Physician _____

How did you hear about our office? ❒ Insurance ❒ Dentist ❒ Patient _____ ❒ other _____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

❒ PATIENT LISTED ABOVE IS FINANCIALLY RESPONSIBLE FOR ACCOUNT (skip to Spouse / Emergency Contact section)

Last name _____ First name _____ Middle initial _____

Birth date _____ Relationship to patient: ❒ Father ❒ Mother ❒ Grandparent ❒ Spouse ❒ Other _____

Address (if different) _____ Social Security # _____

How long at this address_____ ❒ Own ❒ Rent Home phone ( ) _____ Mobile phone ( ) _____

Employer _____ Occupation_____ # Years employed _____

Work phone ( ) _____ Email address(s) _____

SPOUSE / EMERGENCY CONTACT

Last name _____ First name _____ Middle initial _____

Relationship to patient: ❒ Father ❒ Mother ❒ Grandparent ❒ Spouse ❒ Other _____

Address (if different) _____

Home phone ( ) _____ Mobile phone ( ) _____

DENTAL INSURANCE - Please bring your insurance card to the first appointment

PRIMARY policy holder's full name _____ Birth date _____

SSN or Member ID _____ Relationship to Patient _____ Policy holder's employer _____

Home Address (if different) _____ Group # _____

Insurance Company _____ Address _____ Insurance phone # ( )_____

SECONDARY policy holder's full name _____ Birth date _____

SSN or Member ID _____ Relationship to Patient _____ Policy holder's employer _____

Home Address (if different) _____ Group # _____

Insurance Company _____ Address _____ Insurance phone # ( )_____

I hereby authorize White Orthodontics to submit a claim on behalf of the aforementioned patient. I authorize my insurance company to pay the dental benefits to Richard J. White, D.D.S., L.L.C. I authorize the release of any information relating to this claim.

_____ _____

Signature Date

Please complete back side of form

MEDICAL HISTORY

Is patient in good health? ❒ Yes ❒ No HEIGHT: _____ WEIGHT: _____

Does patient have any history of major illness? ❒ Yes ❒ No Please explain: _____

Has the patient been treated for the following:

❒ Yes ❒ No Asthma
❒ Yes ❒ No Anemia
❒ Yes ❒ No Autism
❒ Yes ❒ No Bone Disorders
❒ Yes ❒ No Cancer, tumor, radiation or chemotherapy
❒ Yes ❒ No Diabetes
❒ Yes ❒ No Endocrine Problems
❒ Yes ❒ No Epilepsy
❒ Yes ❒ No Heart defects, heart murmur, rheumatic heart disease
❒ Yes ❒ No Fainting or Dizziness
❒ Yes ❒ No Hepatitis, jaundice, or other liver problems
❒ Yes ❒ No AIDS or HIV positive
❒ Yes ❒ No Kidney Involvement
❒ Yes ❒ No Nervous Disorders
❒ Yes ❒ No Pneumonia
❒ Yes ❒ No Prolonged Bleeding
❒ Yes ❒ No Rheumatic Fever
❒ Yes ❒ No Tuberculosis
❒ Yes ❒ No Other _____

❒ Yes ❒ No Do you take antibiotic pre-medication before any dental procedures?

❒ Yes ❒ No Have Tonsils and Adenoids been removed?
❒ Yes ❒ No Have you been diagnosed with Obstructive Sleep Apnea?
❒ Yes ❒ No Have you been told you snore excessively?
❒ Yes ❒ No Do you feel like you often wake gasping for air?

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

❒ Yes ❒ No Latex (gloves, balloons)
❒ Yes ❒ No Metals (jewelry, clothing snaps)
❒ Yes ❒ No Foods:_____
❒ Yes ❒ No Other: _____

Please list any allergies or drug sensitivity: _____

_____

List any drugs or medications now being taken, give reasons:

_____

_____

_____

DENTAL HISTORY:

❒ Yes ❒ No History of jaw joint problems?
❒ Yes ❒ No Does patient clench their teeth?
❒ Yes ❒ No Does patient notice clicking or popping in either jaw joint?
❒ Yes ❒ No Does patient have difficulty chewing or opening their mouth?
❒ Yes ❒ No Has patient's jaw ever locked?
❒ Yes ❒ No Does patient's bite feel uncomfortable or unusual?
❒ Yes ❒ No Does patient experience soreness in the muscles of their face or around their ears?
❒ Yes ❒ No Has patient been diagnosed or treated for "TMJ" or "TMD" problems?

Have there been any injuries to the face, mouth or teeth? ❒ Yes ❒ No If yes, please explain: _____

Has the patient ever sucked a thumb or fingers? ❒ Yes ❒ No If yes, until what age? _____

Does the patient have any speech problems? ❒ Yes ❒ No _____

Have you been informed of any missing or extra permanent teeth? ❒ Yes ❒ No _____

Has an Orthodontist been consulted previously? ❒ Yes ❒ No

List any musical instruments played: _____

REASON FOR CONSULTATION: _____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I also authorize the dental staff to perform the necessary orthodontic services as needed. 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. This office reserves the right to verify the credit status of potential patients and or/ parents prior to extending credit for treatment fees. I understand that where appropriate, credit bureau reports will be obtained.

Patient Signature _____ Financially Responsible Signature _____

Print Name _____ Print Name _____