ADULT HEALTH HISTORY

smile orthodontics
DRS. STURDIVANT & MANN, P.C.

Date: _____/_____/_____
MM DD YYYY

PATIENT INFORMATION:

Male / Female Birthdate: _____/_____/_____ Age: _____

First Name: _____ Initial _____ Last Name: _____

Preferred Name:_____ Cell: (_____)_____ Work: (_____)_____

Address: _____ **Dentist Name:** _____
Street City/State Zip

Whom may we thank for referring you? **(Circle one:)** *Friend:(Name)* _____

*Dentist Family Google Website Co-Worker Location School Neighbor Marketing Other:*_____

Marital Status: **Single** **Married** **Partnered** **Divorced** **Separated** **Widowed**

PERSON FINANCIALLY RESPONSIBLE:

Name: _____ **Cell :** _____ **Work:**_____

Address: _____ **Email:** _____
Street City/State Zip

(Circle One:) **Self** **Spouse** ***Father*** ***Mother*** ***Stepfather*** ***Stepmother*** ***Guardian*** ***Other:***_____

DENTAL/ORTHODONTIC INSURANCE:

PRIMARY

Dental Insurance Company:_____ SSN or ID# _____

Card Holder Name: _____ Card holder Birthdate: _____/_____/_____

Employer Name: _____ Cell Phone: (_____)_____

Address (if different then above): _____
Street City/State Zip

(Circle One:) *Self Spouse Father Mother Stepfather Stepmother Guardian Other:*_____

Dual Dental Insurance Coverage? **Yes** **No** **If yes, fill out secondary information below…**

SECONDARY

Dental Insurance Company:_____ SSN or ID# _____

Card Holder Name: _____ Card holder Birthdate: _____/_____/_____

Employer Name: _____ Cell Phone: (_____)_____

Address (if different then above): _____
Street City/State Zip

(Circle One:) *Self Spouse Father Mother Stepfather Stepmother Guardian Other:*_____

ADULT HEALTH HISTORY

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Patient Name: _____

PATIENT HEALTH HISTORY:

Medical History: *Check all that apply…*

_____ ADHD

_____ Seizures/Epilepsy

_____ Heart Murmur/Congenital Heart Defect/Pre-Med Needed

_____ Diabetes

_____ Hepatitis or Liver Problems

_____ Prolonged Bleeding/Hemophilia

_____ Operations/stays in hospital

_____ Pregnant

_____ HIV + or AIDS

_____ Bisphosphonate Medication

Dental History: *Check all that apply…*

____ Thumb/finger/lip sucking habits (circle) ___ Continued ___ Discontinued

____ Pain, popping or locking when opening/closing jaw (circle)

____ Have muscle tenderness or stiffness in jaw or neck? (circle)

____ Had previous treatment for TMJ or jaw joint problems?

____ Clinching/Grinding of teeth? *(circle) DAY - NIGHT - BOTH*

____ Any injuries to face, mouth, teeth or chin? (circle)

____ Been evaluated for orthodontic treatment (Second opinion)

____ Had previous orthodontic treatment. When?_____

____ Any known missing or extra permanent teeth?

CONCERNS:_____

MEDICATIONS: _____

Other MedicalConditions/Surgeries:_____

Allergies: *(circle) Latex Metal Nickel Other:* _____

PRIVACY CONSENT: (HIPPA)

Please list the individuals we are allowed to disclose financial and treatment information regarding the patient above.

Name:	***Relationship to Patient:***
_____	_____
_____	_____
_____	_____
_____	_____

I understand that the information I have given is correct to the best of my knowledge, and it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my medical/dental status. I have read the notice of privacy practices. I authorize the orthodontic staff to perform the necessary dental services (including x-rays) that may be needed. I understand that if I take an x-ray performed at Smile Orthodontics to another orthodontic office that I will be charged. I understand that all original documents will be stored electronically. I understand that pictures of my teeth may be used for educational purposes. If this office accepts the assignment of benefit for my insurance, I understand that I am responsible for the payment of services rendered and responsible and responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature_____ Date: _____/_____/_____
MM DD YYYY