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: ____ Email Address: _______________________________

____ Spouse Name: _______________________________
City State Zip

Marital Status: Single Married Partnered Divorced Separated Widowed

Occupation: ____ **Dentist Name:** _________________________________

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

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

PERSON FINANCIALLY RESPONSIBLE **Same information as above:** ________ **(check if yes)**

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

Name:_______________________________________ **Address:** ____
Street City/State Zip

Cell: ( ) ______________________________ **Work: ( )** ______________________________

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

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… (List below)

_____ Currently 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